



Application for a Community Treatment Order

Under Section 51 of the Mental Health Act 2007

MHRT No: _____

DATE: _____

A CTO is a legal order made by the Mental Health Review Tribunal or by a Magistrate. It sets out the terms under which a person must accept medication and therapy, counselling, management, rehabilitation and other services while living in the community. It is implemented by a mental health facility that has developed an appropriate treatment plan for the individual person. CTOs can be made for any period of time up to twelve months. It is possible for a person to have more than one consecutive CTO.

A CTO authorises compulsory care for a person living in the community. If a person breaches a Community Treatment Order, by not complying with the conditions of the Order, the person may be taken to a mental health facility and given appropriate treatment, including medication.

To book a hearing for an application please complete and email a Hearing Application Form to the Tribunal. These forms are available from the Tribunal's website www.mhrt.nsw.gov.au or by phoning 9816 5955.

CLIENT DETAILS

NAME: _____

STREET: _____

SUBURB: _____ STATE: _____ POST CODE: _____

TELEPHONE: _____ EMAIL: _____

DATE OF BIRTH: _____ COUNTRY OF BIRTH _____

GENDER: MALE FEMALE MRN NO: _____

CURRENT ORDER

- None
- Involuntary Patient
- Community Treatment Order expiring on _____
- Tribunal
- Magistrate (please attach a copy of order)

NOTICE OF APPLICATION

The applicant must notify the affected person in writing of the application and include a copy of the proposed treatment plan. If the application is for a person who is not detained in a mental health facility the application cannot be heard by the Tribunal earlier than 14 days after the notice is given.

DATE OF SERVICE: _____ HOW SERVED: _____

APPLICANT DETAILS

NAME: _____

STREET: _____

SUBURB: _____ STATE: _____ POST CODE: _____

TELEPHONE: _____

RELATIONSHIP: _____

CLINICAL DETAILS

Total number of admissions to mental health facilities: _____

First admission date: _____ Date Discharged: _____

Most recent admission date: _____ Date Discharged: _____

REASON FOR APPLICATION**DOES THE CLIENT SUPPORT THE APPLICATION:** YES NO

If no, please identify client's objections or issues with the CTO:

BACKGROUND INFORMATION**SHORT HISTORY OF THE PERSON'S ILLNESS:**

CURRENT MEDICATION AND ANY CHANGES TO MEDICATION DURING LAST 6 MONTHS:

ANY OTHER CONDITIONS AND THEIR TREATMENT (e.g. substance abuse, developmental disability, psychosocial issues)

EFFICACY OF COMMUNITY TREATMENT ORDER OVER THE PERIOD OF THE ORDER (if applicable)

ANY DIFFICULTIES IN ASSISTING THE CLIENT DURING THE CURRENT ORDER:

FAMILY AND COMMUNITY SUPPORT (include issues of non-support if applicable)

PLANS FOR PERSON DURING THE PROPOSED ORDER (e.g. follow-up, rehabilitation, substance abuse issues, psycho-education)

OTHER PEOPLE INVOLVED

Please provide the details of the primary carer and any other people who may be able to give information to the Tribunal about the application eg. close friends, relatives, or other involved professionals.

NAME: _____

STREET: _____

SUBURB: _____ STATE: _____ POST CODE: _____

TELEPHONE: _____

RELATIONSHIP: _____

Does this person support this application? Yes No Not known

NAME: _____

STREET: _____

SUBURB: _____ STATE: _____ POST CODE: _____

TELEPHONE: _____

RELATIONSHIP: _____

Does this person support this application? Yes No Not known

REQUESTED HEARING ARRANGEMENTS

Preferred Date for hearing: _____ AM PM

Preferred venue: _____ Video Phone In Person

Interpreter required: No YES – language: _____

DECLARATION

I have read this completed application and believe that to the best of my knowledge all of the information provided is true, complete and accurate.

Signature of applicant: _____ Date: _____

Please return the completed application with the proposed treatment plan and other supporting evidence to MHRT-Civil@health.nsw.gov.au

For further information or assistance please contact the Tribunal on 1800 815 511

MHRT USE ONLY – BOOKING DETAILS

DAY: _____ 1 2 3 LIVE VIDEO
 DATE: ____/____/____ 4 OVP PEXIP PAPERS
 TIME: _____ BOARD PHONE

HEARING APPLICATION FORM

Civil Jurisdiction – Mental Health Act 2007
 PO Box 247 Gladesville NSW 1675 | Tel. 1800 815 511
 Email: MHRT-Civil@health.nsw.gov.au
 Website: www.mhrt.nsw.gov.au



CLIENT DETAILS

MHRT NO: _____ **MRN:** _____

Surname: _____ Given name(s): _____
 Date of birth: _____ Male Female Aboriginal/Torres Strait Islander
 Disability: None Vision Hearing Mobility Other: _____
 Country of birth: _____ Interpreter: No Yes – language: _____
 Address: _____
 Home phone: _____ Mobile phone: _____

CURRENT ORDER DETAILS

NONE MHRT MAGISTRATE CTO – Expiry date: _____
 VOLUNTARY INVOLUNTARY Date detained: _____ Date involuntary: _____
 Mental Health Facility: _____

CURRENT APPLICATION (Please refer to the relevant section(s) of the [appropriate hearing kit](#) regarding requirements)

- | | |
|---|--|
| <input type="checkbox"/> s34 Mental Health Inquiry | <input type="checkbox"/> s44 Appeal against a refusal to discharge |
| <input type="checkbox"/> s37(1)(a) Initial review after mental health inquiry | <input type="checkbox"/> s37(1)(c) 6 mthly review after first 12 months |
| <input type="checkbox"/> s37(1)(b) 3 mthly review within first 12 months | <input type="checkbox"/> s37(1A) Review at any other time |
| <input type="checkbox"/> s9 Review of voluntary patient | |
| <input type="checkbox"/> s94(2) ECT Administration – involuntary patient | <input type="checkbox"/> s93(3) ECT Administration – voluntary patient |
| <input type="checkbox"/> s94(2A) ECT Administration – under 16 years <input type="checkbox"/> voluntary <input type="checkbox"/> involuntary | |
| <input type="checkbox"/> s101(1) Consent to surgery | <input type="checkbox"/> s103 Consent to special medical treatment |
| <input type="checkbox"/> s46 NSW TGA Application for financial management order | <input type="checkbox"/> s48 NSW TGA Review of interim FMO |
| <input type="checkbox"/> s67(2) Appeal against Magistrate’s CTO | <input type="checkbox"/> s63 Review of detained person on CTO |

s51 Community treatment order New Renew existing

APPLICANT NAME: _____ **TITLE:** _____ **PHONE:** _____

- Authorised Medical Officer Medical Practitioner Designated Carer/Principal Carer/NSW Guardian
 Director Community Treatment Deputy Director Community Treatment (delegate)

The applicant must be an Authorised Medical Officer of a mental health facility in which the client is detained or is a patient; a Medical Practitioner, a Director (or Deputy Director delegate) of Community Treatment who is familiar with the client’s clinical condition; the designated carer, the principal carer or the NSW Guardian for the client.

Client has been notified of the application Carer has been notified of the application

Declared Community Health Facility: _____

HEARING VENUE NAME: _____

Venue address: _____
 Date preferred: _____ Time preferred: _____
 Hearing type: Live Video – VMR: _____ Phone – number: _____
 Contact name: _____ Position: _____ Mobile: _____
 Phone: _____ Fax: _____ Email: _____

MHRT USE ONLY – CONFIRMATION OF BOOKING

- Notice to be served by: ____/____/____ Applicant advised
 Confirmed Date: ____/____/____ Confirmed by: _____
 MHAS required Security required Letter posted to client

OTHER DETAILS: _____

