

MENTAL HEALTH ORDERS- APPLICATION FORM

*For use by professional person
Mental Health (Treatment and Care) Act 1994

I _____

Of _____

Wish to apply for:

- Psychiatric Treatment Order**
Duration of Order Sought _____; **or** *[Complete parts 1 – 10]*
- Community Care Order**
Duration of Order Sought _____; **and/or** *[Complete parts 1 – 10]*
- Restriction Order – Content to consider:**
[please list]
- _____
- _____

- Electro Convulsive Therapy** *[Second Independent Psychiatric opinion must be attached]*
Expiry date of Section 28 order: ____/____/____
- Emergency Electro Convulsive Therapy**
- Revocation of Restriction Order**
- I ALSO APPLY FOR AN ASESMENT ORDER TO SUPPORT THIS APPLICATION**

in respect of:

Mr/Mrs/Miss/Ms _____
(Given Names) *(Surname)*

Address: _____

Postcode _____

Date of Birth: ____/____/____

Date of Application: _____/_____/_____

Is the said person under 18 years **Yes** **No**

[If yes please provide details of parent/s or Legal Guardian]

Name: _____

Address: _____ **Postcode:** _____

Telephone: (H) _____ **(W)** _____

Is the person subject to a guardianship or management of property order?

Yes No

[If yes, please provide details of Guardian and/or Manager]

Name: _____

Address: _____ **Postcode:** _____

Telephone: (H) _____ **(W)** _____

Is the said person currently an inpatient? Yes No

PSU **Calvary OPMHIU**

Is this application abridging time limits established by the legislation? If so, please give reasons

I DO SOLEMNLY AND SINCERELY DECLARE THAT:

1. I believe on reasonable grounds, that the said person:

(a) is unable because on mental dysfunction or mental illness-

(i) to make reasonable judgements about matters relating to his/her health or safety; or

(ii) to do anything necessary for his/her health or safety;

and as a result, the said person's health or safety is, or is likely to be, substantially at risk;

OR

8(a) Who is to prescribe and administer treatment?

(b) How, when and where is the respondent to receive treatment?

[outline plans for transition to community care – indicate Carer’s view where appropriate]

(c) Is the said person currently assigned a case manager? If not, is a case manager to be assigned?

[Please state details (including the name and location of the case manager)]

(d) Are any other services required?

[eg: education, rehabilitation, counselling care and support etc]

(e) Does the said person require supported accommodation?

[If so, please give details]

9. Would the risk to the said person’s health or safety or the danger to the community increase substantially should the said Person appear before the Tribunal?

Yes *[go to Part 10]* No *[go to Part 11]*

10. If yes, please provide grounds to support your statement in Part 9.

11. The following person/s would be able to assist the Tribunal or are otherwise interested in the health and welfare of the said person.

[Please provide name, address and contact telephone numbers add attachment if insufficient space].

(i) Name

Address

PH: _____(H) _____(W)

(ii) Name

Address

PH: _____(H) _____(W)

And I make this solemn declaration by virtue of the Commonwealth's *Statutory Declarations Act 1959*, and subject to the penalties provided by that Act for the making of false statements in statutory declarations, conscientiously believing the statements contained in this declaration to be true in every particular.

[Signature of person making declaration]

Declared at Canberra

The _____ day of _____.

Before me: _____
(Signature and title of person before whom the declaration is made)