Protective Division – Mental Health Stream

Mental Health Act 2013

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| Application for Authorisation of Treatment of a Forensic Patient | S 88 |

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| 1 | **The patient** *(complete or alternatively, if patient label available, please affix)* | | | | | | | |
| Name | |  | | | | | | |
| Address | |  | | | | | | |
| Suburb | |  | State |  | | | P/code |  |
| DoB | |  | | | | | | |
| Gender | | Male  Female  Other | | | | | | |
| Email | |  | | | | | | |
| Phone | |  | | Mobile |  | | | |
| Facility | |  | | Patient ID | |  | | |

Aboriginal or Torres Strait Islander ?  Yes  No

Is a Guardianship Order in place? Yes No

Is the patient supporting dependent children? Yes No

Is the patient supporting frail/ elderly family members?  Yes  No

Does the patient require an Interpreter?  n/a Language/dialect: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the patient have a representative/support person(s)?  Yes  No

Representative/support person 1 (as nominated by the patient):

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Name |  | | | | | | |
| Address |  | | | | | | |
| Email |  | | | | | | |
| Suburb |  | State |  | | | P/code |  |
| Phone |  | | | Mobile |  | | |

Relationship to patient:

|  |  |  |  |
| --- | --- | --- | --- |
| Partner/Spouse | Parent | Sibling | Case Manager |
| Lawyer/Advocate | Other: |  | |

Representative/support person 2 (as nominated by the patient):

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Name |  | | | | | | |
| Address |  | | | | | | |
| Email |  | | | | | | |
| Suburb |  | State |  | | | P/code |  |
| Phone |  | | | Mobile |  | | |

Relationship to patient:

|  |  |  |  |
| --- | --- | --- | --- |
| Partner/Spouse | Parent | Sibling | Case Manager |
| Lawyer/Advocate | Other: |  | |

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| 2 | **Criteria for Authorisation of Treatment** | |
| The tribunal may authorise treatment for a forensic patient if satisfied that *all* of the following criteria apply. Please address all criteria outlined below.  (a) the treatment has been recommended and applied for by an *Approved Medical Practitioner* (the applicant)  Applicant | | | |
| Address | |  |
| Telephone | |  |

(b) the patient has a mental illness. *Outline the nature of the patient’s mental illness and symptoms*:

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(c) without treatment, the mental illness will, or is likely to, *seriously harm* –

- the patient’s *health* or *safety*; or

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| - the *safety* of *other persons* |
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(d) the treatment will be appropriate and effective – *detail anticipated treatment outcomes*, including how the treatment is expected to impact on the patient’s current presentation

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(e) the patient does not have decision-making capacity to make a decision about assessment and/or treatment. Please attach decision-making capacity form *or* outline the date and details of the most recent assessment of decision-making capacity with reference to the patients *understanding* of information relevant to the decision; *retaining* of information relevant to the decision; *using or weighing* information relevant to the decision or *communication* of the decision.

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| 3 | **Patient History and Treatment** | |
| Provide details of relevant psychiatric history, prior diagnoses, admissions, symptoms and any prior involuntary orders: | | |
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| Describe the events/circumstances leading to this application for the authorisation of treatment: | | |
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| Treatment currently being administered: |
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| Details of any medical issues and contraindications to the proposed treatment: |
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| Proposed psychological therapies: |
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| Details of any alcohol or substance use issues: |
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| 4 | **Interim Authorisation of Treatment** | |
| Is interim authorisation required? | | ☐ Yes ☐ No |
| If yes, would achieving the treatment outcomes be compromised by waiting for the treatment to be authorised by the Tribunal? | |  |
| Please provide details: | |  |
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| 5 | **Treatment Requested by the Applicant for authorisation (complete in full)** |
| * Please name all of the classes of medications being applied for (complete below): | |
| 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
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| * What tests will the patient be required to submit to:   blood  medical  urine  diagnostic radiological and/or medical imaging  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| * Is authorisation sought for ECT treatment? Yes  No   If yes please complete section 6 below   * Any other orders sought: | |
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| 6 | **ECT** |
| Outline the rationale for requesting authorisation of ECT: | |
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| What is the patient’s attitude to ECT: |
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| What is the family or carer’s attitude to ECT: |
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| Has the patient had ECT before and, if so, when and to what effect: |
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| **Signed by the Applicant** | | **Print name** | |
|  | |  | |
| Date |  |  |  |

This application should be sent via email to: [applications.mentalhealth@tascat.tas.gov.au](mailto:applications.mentalhealth@tascat.tas.gov.au)

**STATEMENT OF RIGHTS**

The Tribunal will hold a hearing to determine this application for an authorisation of treatment. The hearing will be held as soon as practicable. The Tribunal will advise you of the time and place of that hearing. You do not have to attend the hearing, however, if you chose to attend, you have a number of rights at that hearing, including the following:

* the right to be represented by a lawyer or another person of your choosing;
* the right to put before the Tribunal material that you want it to take into account in making its decision, including:
  + giving information to the Tribunal yourself; and/or
  + asking others to give the Tribunal information;
* the right to ask questions of about written material presented to the Tribunal, including the application for treatment order and the treatment plan;
* the right to ask make oral or written submissions to the Tribunal;
* the right to an interpreter; and
* the right to apply for an adjournment.

Additional information about the process for determining applications can be obtained from the TASCAT website at [www.tascat.tas.gov.au](http://www.tascat.tas.gov.au) or by contacting the Tribunal on 1800 657 500.