 Protective Division – Mental Health Stream

Mental Health Act 2013

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| Application for Renewal of Treatment Order (Child) | S 48 |

**An application for renewal of a treatment order must be made at least 10 days prior to the expiry of the order to be valid. For administration purposes, please submit this application at least 14 Days before the expiration of the current treatment order**.

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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 | | |  | | |

Please indicate the status of the patient at the time of this applicationInpatient Outpatient

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 or other assistance with communication?  Yes  No

Type of assistance required:

Interpreter - language/dialect: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other – please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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: |  | |

Person responsible / Family / Other:

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

Relationship to patient:

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

|  |  |  |
| --- | --- | --- |
| 2 | **Approved medical practitioner making the application** | |
| Name | |  |
| Address | |  |
| Telephone | |  |
| AMP status expiry date | |  |

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| 3 | **Current Treatment Order** | |
| Details of the current order | | |
| Order number | |  |
| Date of order | |  |
| Date of expiry of order | |  |
| Treating medical practitioner | |  |
| Date of last assessment | |  |

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| 4 | **History** | | |
| **Provide details of the relevant psychiatric history, prior diagnoses, admissions, symptoms and any prior involuntary orders:** | | | |
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| **Describe any events/circumstances since the treatment order was last reviewed by the Tribunal:** | | | |
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| 5 Statement addressing treatment criteria | | S48(3)(c) |

Under s 48(3)(c) of the *Mental Health Act 2013* (the Act), the applicant for renewal of a treatment order **must** provide a statement **affirming that (and explaining how)** the person meets the treatment criteria and is expected to continue to meet those criteria for the period of renewal.

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| A | **s40 (a) The patient has a mental illness – please outline the nature of the patient’s mental illness and current symptoms** | |
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| B | **s40 (b) Without treatment, the mental illness will, or is likely to, seriously harm the patient’s health or safety or the safety of other persons** | |
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| C | **s40 (c) The treatment will be appropriate and effective** | |
| **Proposed treatment setting or settings:** | | |
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| **Treatment currently being administered (including psychological and details of any side effects associated):** | | |
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| **Proposed future treatment (including any other proposed interventions eg. blood tests, urine tests, diagnostic radiological or medical imaging):** | | |
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|  | | |
| **Why proposed future treatment is appropriate and effective (including details of anticipated treatment outcomes and how the treatment proposed will impact on the patient’s current presentation):** | | |
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| D | **s40 (d) The treatment cannot be adequately given except under a treatment order** | |
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| E | **s40 (e) The patient does not have decision making capacity** | |
| |  | | --- | | **(a) is the patient unable to make decision about their own assessment or treatment because of an impairment of, or disturbance in, the functioning of the mind or brain**  Yes. Explain how:  No | |  |  |  | | --- | | **AND**  **(b) is the patient unable to**  **(i) understand information relevant to the decision;**  Yes. Explain how:  No | |  | |  | | **(ii) retain information relevant to the decision;**  Yes. Explain how:  No | |  | |  | |  | | **(iii) use or weigh information relevant to the decision;**  Yes. Explain how:  No | |  | |  | |  | | **(iv) communicate the decision (whether by speech, gesture, or other means).**  Yes. Explain how:  No | | | |
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|  | | |
| **(iv) communicate the decision (whether by speech, gesture, or other means).**  Yes. Explain how:  No | | |
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| |  |  |  |  | | --- | --- | --- | --- | | 6 | **Capacity** | |  | | Is the patient sufficiently mature to make decisions regarding his or her treatment? | | Yes  No |  | | If yes, please provide details: | | |  | |  | | |  | |  | | |  | |  | | |  | |  | | |  | | Is a patient able to provide informed consent to treatment? | | Yes No |  | | If no,   * advise if the patient’s parents have been consulted regarding treatment: | | Yes  No |  | | Please provide details of all consultation that has occurred, including the date of any family meetings, the parties attending and the outcome: | | |  | |  | | |  | |  | | |  | |  | | |  | |  | | |  | | If a parent is not able to prove consent, please advise relationship status between the parent and the child – e.g. history of abuse, whether the patient lives with the parents, whether Child Protection is involved: | | |  | |  | | |  | |  | | |  | |  | | |  | |  | | |  | | Have the patient’s parents consented to the treatment? | | Yes  No |  | | Please provide details, including attaching a copy of a signed consent form: | | |  | |  | | |  | |  | | |  | |  | | |  | |  | | |  | | If the patient’s parents have consented to treatment, please advise why a treatment order is still required: | | |  | |  | | |  | |  | | |  | |  | | |  | |  | | |  | |  | | |  | | | |
| 7 | **Treatment Order (this section must be completed in full)** | | |
| Please provide details of the treatment order sought: | | | |
| * If the patient is currently detained for treatment, name the approved facility below:   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   |  | | --- | | The hospital has facilities/staff to accommodate the patient  Yes  No | | The hospital is the most appropriate place to accommodate the patient  Yes  No | |  | | | | |
| |  | | --- | | * Please select all of the classes of medications being applied for (complete below): | | Antipsychotic | | Mood stabilising | | Antidepressant | | Benzodiazepine | | Anticholinergic | | other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| * Will the patient be required to attend community mental health appointments  Yes  No   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| * What tests will the patient be required to submit to:   blood  medical  urine  diagnostic radiological and/or medical imaging  other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |  | |
| * The patient will be subject to home visits: | | Yes  No | |
| * Any other orders sought:   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   * Is ECT is required?  Yes (complete section 8 below)  No | |  | |
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|  | |  | |
| 8 | **ECT** | | |
| When is it proposed to commence ECT treatment? If ECT is required urgently please provide details: | | Yes  No | |
| When is it proposed to commence ECT treatment? If ECT is required urgently please provide details: | | | |
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| Have you ascertained the patient’s views to ECT treatment and is so, what are they?: | | | |
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| Have you ascertained the family’s views to ECT treatment and is so, what is it?: | | | |
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| Has the patient had ECT before and, if so, when and to what effect?: |
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| What is the anticipated outcome of ECT?: |
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| 9 | Duration of Order Sought: |

*NB: A treatment order may be renewed for up to six (6) months on the first renewal and up to twelve (12) months thereafter.*

I have:

provided a copy of the application and accompanying documentation to the patient;

placed a copy of the application and accompanying documentation on the patient’s clinical records;

made a note in the patient’s clinical record to the effect that these actions have been completed; and

provided a copy of the application to the Chief Civil Psychiatrist (per section 48(4)(b)(ii)MHA).

**Please note that failure to provide the patient with a copy of the application and accompanying documentation may result in the application being invalid.**

Attached are copies of:

the current treatment order; and

the treatment plan

|  |  |  |  |
| --- | --- | --- | --- |
| **Signed by the applicant:** | | **Please print name:** | |
|  | |  | |
| Applicant’s title: | |  | |
| Name of treating consultant: | |  | |
| Date: |  | Time: |  |

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 renewal of treatment order (as per section 48 of the Act). The Tribunal will arrange for the hearing to occur as soon as practicable after the application to renew the treatment order is lodged, and will advise you of the date, time and place of the hearing. You do not have to attend the hearing, however, if you choose to attend, you have a number of rights at that hearing, including the following:

* the right to be represented by a lawyer, advocate 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 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 or by contacting the Tribunal on 1800 657 500.