Protective Division – Mental Health Stream

Mental Health Act 2013

|  |  |
| --- | --- |
| Application for Variation to Treatment Order | S 181(2) |

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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 application:InpatientOutpatient

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 | **The approved medical practitioner making the application** | |
| Name | |  |
| Address | |  |
| Telephone | |  |
| AMP status expiry date | |  |

|  |  |
| --- | --- |
| 3 | **Treatment currently being administered** |
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|  | |
|  | |

|  |  |  |  |
| --- | --- | --- | --- |
| 4 | **Details of variation sought** | | |
| Change in medicationChange in other treatment  ECT – if yes complete section 5 below  Provide reasons for the variation sought: | | | |
|  | | | |
|  | | | |
| 5 | **ECT** | | |
| When is it proposed to commence ECT? | | | |
|  | | | |
|  | | | |
|  | | | |
|  | | | |
| Have you ascertained the patient’s views to ECT treatment? If so, what are they?: | | | |
|  | | | |
|  | | | |
|  | | | |
|  | | | |
| Has the patient had ECT before? If so, when and to what effect?: | | | |
|  | | | |
|  | | | |
|  | | | |
|  | | | |
| What is the anticipated outcome of ECT?: | | | |
|  | | | |
|  | | | |
|  | | | |
|  | | | |
| 6 | **Commencement of variation** | | |
| What date is the varied treatment to commence from: | | |  |
| Has the patient been consulted? | | | Yes  No |
| What are the patient’s views? | |  | |
|  | |  | |
|  | |  | |

|  |  |  |
| --- | --- | --- |
| 7 | **Details of Order** | |
| Matter number | |  |
| Expiry date of order | |  |
| Name of treating medical practitioner | |  |

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

Attached is a copy of:

the treatment plan

**Information about lodging the application**

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

Incomplete or otherwise invalid applications will not be considered – the registry will notify the Legal Orders Coordinator as soon as possible if this is the case.

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

**STATEMENT OF RIGHTS**

The Tribunal will arrange for this application for variation of treatment order to be considered and determined by a panel of the Tribunal. This may or may not involve a hearing.

If the Tribunal holds a hearing to determine this application you will be advised 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](http://www.tascat.tas.gov.au)](http://www.mentalhealthtribunal.tas.gov.au) or by contacting the Tribunal on 1800 657 500.