Protective Division – Mental Health Stream

Mental Health Act 2013

|  |  |
| --- | --- |
| Application for Variation to an Authorisation of Treatment Order for a Forensic Patient | S 192A |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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 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: |  | |

|  |  |  |
| --- | --- | --- |
| 2 | **The applicant** | |
| Name | |  |
| Address | |  |
| Telephone | |  |

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

|  |  |  |
| --- | --- | --- |
| 4 | **Details of Variation Sought** | |
| Change in medicationChange in other treatment  Provide reasons for the variation sought: | | |
|  | | |
|  | | |
|  | | |
|  | | |
| Is ECT sought as part of the interim treatment order or treatment order? Yes  No  If so, | |
| When is it proposed to commence ECT? If ECT is required urgently under an interim treatment order (prior to the hearing of the application before a three member Tribunal panel), please provide details: | | |
|  | | |
|  | | |
|  | | |

|  |  |  |  |
| --- | --- | --- | --- |
| Have you ascertained the patient’s attitude to ECT and if so, what is it: | | | |
|  | | | |
|  | | | |
|  | | | |
|  | | | |
| Have you ascertained the family’s attitude to ECT and if so, what is it: | | | |
|  | | | |
|  | | | |
|  | | | |
|  | | | |
| Has the patient had ECT before and, if so, when and to what effect: | | | |
|  | | | |
|  | | | |
|  | | | |
|  | | | |
| What is the anticipated outcome of ECT (as opposed to ECT not being authorised): | | | |
|  | | | |
|  | | | |
|  | | | |
|  | | | |
| 5 | **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? | |  | |
|  | |  | |
|  | |  | |
|  | |  | |
|  | |  | |
|  | | | |

|  |  |  |
| --- | --- | --- |
|  | | |
| 6 | **Details of Order** | |
| Matter number | |  |
| Expiry date of order | |  |
| Name of treating medical practitioner | |  |

**I certify the following:**

the patient has been given a copy of this application; and

a copy of the application has been placed on the patient’s clinical record.

**I have attached:**

a copy of the Decision-Making Capacity Form.

|  |  |  |  |
| --- | --- | --- | --- |
| **Signed by the Applicant:** | | **Please print name:** | |
|  | |  | |
| 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 variation 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.