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| Application for ReviewSections 79(1), 80(1) and 81(1) Mental Health (Compulsory Assessment and Treatment) Act 1992 |

To: The Convenor

Mental Health Review Tribunal

PO Box 10407

Wellington, 6140

 Tel 0800 114 645

# Instructions

(i) Please tick the relevant boxes.

(ii) All sections must be completed.

(iii) Unless specified, it will be assumed that the patient is the applicant.

# Patient details (if the patient is not the applicant, please also complete the box on page 3)

|  |
| --- |
| Patient’s full name |
|       |
| Patient’s contact address |
|       |
| Phone | Fax |
|       |       |
| Place of treatment |
|       |
| Phone | Fax |
|       |       |
| Date of birth |  | Gender |  |
|   |   |   |   |   |   |   |   |  |   |  |
| Ethnicity |  |
| [ ]  | Māori – iwi affiliation       | [ ]  | New Zealand European |
| [ ]  | Samoan | [ ]  | Tongan |
| [ ]  | Asian – If Asian, indicate ethnicity –       | [ ]  | Fijian |
| [ ]  | Cook Islander | [ ]  | Other –       |

# Nature of order

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| (a) Compulsory treatment |  | (b) Special patient |  | (c) Restricted patient |
| (i) s29 community | [ ]  | (i) s24(2)(a)\* unfit to stand trial | [ ]  | s55 | [ ]  |
| (ii) s30 inpatient | [ ]  | (ii) s24(2)(a)\* insanity | [ ]  |  |  |

\* Criminal Procedure (Mentally Impaired Persons) Act 2003 (or equivalent under the Criminal Justice Act 1985)

|  |  |
| --- | --- |
| Date of current order |  |
|   |   |   |   |   |   |   |   |  |

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| **Criminal proceedings:** If the patient is under a s29 community treatment order or a s30 inpatient treatment order, does that result from an order being made in criminal proceedings? |
| [ ]  | Yes |
| [ ]  | No |
| Date of last clinical review |  |
|   |   |   |   |   |   |   |   |  |
| Is the patient an inpatient living in the community on extended leave? |
| [ ]  | Yes |
| [ ]  | No |
| If the patient is either under a s29 community treatment order or a s30 inpatient order is that order: |
| [ ]  | (1) a six-month order? |
| [ ]  | (2) an indefinite order? |
| Name and address of responsible clinician |  | Name and address of welfare guardian |
|       |  |       |
| Phone |  | Fax |  | Phone |  | Fax |
|       |  |       |  |       |  |       |

# Hearing

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| **Ethnic identity:** Pursuant to s103 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 a patient or applicant can request the Review Tribunal to co‑opt a suitable person of the same ethnic identity as the patient. |
| Does the patient and/or the applicant wish the Tribunal to co‑opt a person of the same ethnicity as the patient? |
| [ ]  | Yes |
| [ ]  | No |
| If yes, please identify ethnicity:       |
| **Interpreter** |
| Is an interpreter required? |
| [ ]  | Yes |
| [ ]  | No |
| If yes, please specify language:       |

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| To be completed if the applicant is not the patient |
|  | Full name of applicant |       |  |
| Address of applicant |       |
| Contact telephone number for applicant |       |
| Relationship to patient | [ ]  Welfare guardian |
| [ ]  Principal caregiver |
| [ ]  Usual medical practitioner |
| [ ]  District inspector |
| [ ]  Official visitor |
|  |

Dated this       day of       20

|  |  |  |
| --- | --- | --- |
| Applicant’s signature |  | Applicant’s full name |
|       |  |       |

# NB. If a Certificate of Clinical Review is available, please attach.