MENTAL HEALTH REVIEW TRIBUNAL

RESET FORM SUBMIT FORM

MHRT No: _____

Date Reg'd:

APPLICATION FOR A FORENSIC COMMUNITY TREATMENT ORDER

Under section 99 of the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* for a forensic patient, correctional patient or inmate in a correctional centre or detention centre

In making this application, please refer to the Tribunal's Practice Directions: Forensic No.6 and No.7

DETAILS OF THE CLIENT

NAME: _____

ADDRESS: _____

TELEPHONE: _____

DATE OF BIRTH: _____ COUNTRY OF BIRTH: _____

☐ **MALE** ☐ **FEMALE** ☐ **ABORIGINAL OR TSI** **MIN:** _____

CURRENT STATUS:

☐ Inmate in a correctional centre or detention centre ☐ Forensic Patient

☐ Inmate subject to transfer order ☐ Correctional Patient

DETAILS OF THE APPLICANT

NAME: _____

ADDRESS: _____

TELEPHONE: _____

EMAIL: _____

RELATIONSHIP *(e.g., medical officer, psychiatrist)* : _____

HOW LONG DO YOU WANT THE ORDER TO BE FOR? *(max 12 months)*: _____

REASON FOR APPLICATION:

DOES THE CLIENT SUPPORT THE APPLICATION: ☐ **YES** ☐ **NO**

OTHER PEOPLE INVOLVED

Please provide the details of the designated carer(s), principal care provider and any other people who may be able to give information to the Tribunal about the application e.g., close friends, relatives, or other involved professionals. If you would liketo add more names please attach an extra sheet.

NAME: _____

ADDRESS: _____

TELEPHONE: _____

EMAIL: _____

RELATIONSHIP: _____

Supportive of this application? ☐ Support ☐ Oppose ☐ Don't know

HEARING ARRANGEMENTS

*This application should be made **6 weeks** prior to the requested date for the hearing.*

Upcoming court dates *(if applicable)* **:** _____

Release date *(if known)* **:** _____

Availability for hearing:

	Mon	*Tue*	*Wed*	*Thu*	*Fri*
Mornings	☐	☐	☐	☐	☐
Afternoons	☐	☐	☐	☐	☐

Other information about availability:

Interpreter required: ☐ NO ☐ YES – Language: _____

Does the person want to speak to a lawyer before the hearing? ☐ YES ☐ NO

If yes, please assist the person contact the Mental Health Advocacy Service through LawAccess on 1300 888 529.

DECLARATION

I have read this completed application and believe that to the best of my knowledge the information provided is true, complete and accurate.

Signature of applicant: _____ Date: _____

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Please return the completed application to MHRT-Forensic@health.nsw.gov.au