Mental Health Act 2014
Sections 60, 66, 272, 278, 284 & 294

MHA 114
Application to Mental Health Tribunal

Mental Health Statewide UR Number

Local Patient Identifier										

FAMILY NAME

GIVEN NAMES

DATE OF BIRTH | SEX

Place patient identification label above

MHA 114

Instructions to complete this form

- This form is to be used when a compulsory or security patient wants to make an application against:
  - their treatment order (complete Part A)
  - transfer to another designated mental health service (complete Part B)
  - refusal by authorised psychiatrist to grant a security patient leave of absence (complete Part C)
- This form may be completed by:
  - the patient or any person at the request of the patient
  - a guardian, a parent if the patient is under 16 years, the Secretary to the Department of Human Services or delegate if the person is the subject of a custody to the Secretary order or a guardianship to the Secretary order.
- Please ☑ the type of application you want to make.
- Please print and use BLOCK letters.

GIVEN NAMES FAMILY NAME (BLOCK LETTERS) of patient

address:

address of patient

a patient of:

name of designated mental health service

To the Mental Health Tribunal

☐ **Part A: Application against treatment order**
(tick ☑ here)

1. I am a compulsory / security patient.
2. I do not want to be on a treatment order.
3. I want the Tribunal to revoke my Order / discharge me as a security patient.

☐ **Part B: Application against transfer to another designated mental health service**
(tick ☑ here)

1. The authorised psychiatrist has transferred me / is going to transfer me to the following designated mental health service:

name of receiving designated mental health service

2. I do not / did not want to be transferred.
3. I want the Tribunal to review the decision.

☐ **Part C: Application against refusal to grant leave of absence (security patients only)**
(tick ☑ here)

1. I am a security patient.
2. The authorised psychiatrist has refused to grant me the following leave of absence:

3. I want the Tribunal to review the decision.

Signature: Date:

signature of person making application

Given Names: Family Name:

Address: Telephone:

If you are not the patient, please indicate your relationship to the patient:

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JULY 2014

Next steps

After completing this form:

- **send** a copy of this form to the Mental Health Tribunal:
  - Email: mht@mht.vic.gov.au
  - Fax: 9032 3223
  - Mail: Level 30, 570 Bourke Street, Melbourne 3000; or
  - **ask** a member of staff at the mental health service to send the application to the Tribunal.
- **get** more information from the Tribunal:
  - Tel: 9032 3200
  - Tel: 1800 242 703 (toll free)
  - Web www.mht.vic.gov.au

Privacy statement

The information collected on this form will be used by the Mental Health Tribunal to schedule a hearing. The Tribunal will notify you and the designated mental health service that a hearing has been scheduled. It will request the service to provide information about you and your treatment. The Tribunal will use this information to help it decide your application. The exchange of information between the Tribunal and the designated mental health service is authorised under the **Mental Health Act 2014**.

The Tribunal will keep your information secure and not disclose it for any other purpose unless it is required by a law. You can access information held about you by the Tribunal by contacting the Tribunal at the address above.