mental health tribunal
western australia

Application
Mental Health Act 2014 (WA)

Application for Review of a Decision Affecting Rights
s 434(1)

The patient

Name
Postal address
Email address
Contact phone
Date of Birth

Day Month Year

The applicant (if not the patient)

Name
Postal address
Email address
Contact phone

Relationship to patient

- ☐ carer
- ☐ close family member
- ☐ personal support person (choose one)
- ☐ mental health advocate
- ☐ lawyer
- ☐ other (specify) ______________________________

Lawyer/advocate/nominated person/support person(s) (if not the applicant)

Name
Postal address
Email address
Contact phone

Relationship to patient ☐ lawyer ☐ advocate ☐ nominated person ☐ support person

Decision you want reviewed

Please attach a copy of the decision you want reviewed

Date of decision: ____________________

Type of decision: ____________________

Name of person who made the decision: ____________________

Name of mental health service: ____________________

What decision do you want the Tribunal to make and why?

Signature Date

Please send your application to:

The Registrar
Mental Health Tribunal
PO Box Z5272
Perth St Georges Tce WA 6831

email: registry@mht.wa.gov.au

If you have any queries, please telephone the Registry staff on (08) 6553 0060