MHA5

Mental Health Act 1986

Sections 29, 39, 49 & 52(4)

Local Hospital Patient Number: | | | | | | | | | | |

Family Name: _____

Given Names: _____

Date of Birth: _____ **Sex:** _____

Mental Health Statewide Patient Number | | | | | | | | |

Alias: _____

APPEAL TO THE MENTAL HEALTH REVIEW BOARD

Notes to completing this form

Appeals

A patient may appeal to the Board at any time.

A community visitor or any other person who satisfies the Board of a genuine concern for the patient may make an appeal on behalf of an involuntary or security patient.

Further information

To find out more about the Board:

- Ask your case manager or another member of the treating team for the relevant patients' rights booklet.
- Call the Board on the number below.
- Visit the Board's website at **www.mhrb.vic.gov.au**

Privacy Statement

The information being collected on this form will be used by the Mental Health Review Board to schedule your appeal hearing. The Board will notify you and the approved mental health service that a hearing has been scheduled. It will request the service to provide information about you and your treatment. The Board will use this information to help it decide your appeal. The exchange of information between the Board and your treating mental health service is authorised under the **Mental Health Act 1986.**

The Board will keep your information secure and not disclose it for any other purpose unless there is a legal requirement for it to do so. You can access information held about you by the Board by contacting the Executive Officer at the address shown.

TO THE EXECUTIVE OFFICER MENTAL HEALTH REVIEW BOARD

_____
GIVEN NAME/S FAMILY NAME (BLOCK LETTERS) of patient

_____
address of patient if living in the community

I am a patient of: _____
approved mental health service

I wish to appeal against:
(please cross ☒)

☐ being an **involuntary patient.**

- ☐ in hospital
- ☐ on a community treatment order (CTO)
- ☐ on a restricted community treatment order (RCTO)

☐ being a **security patient**

☐ my **transfer** to: _____
another approved mental health service

☐ the refusal of the Chief Psychiatrist to grant me special leave (security patients only).

I wish to appeal because: _____

_____

_____

_____

_____

_____

_____

_____

_____

Signed: _____ Date: | | | | | | | | |

TO BE COMPLETED IF A PERSON MAKES AN APPEAL ON BEHALF OF A PATIENT

I wish to appeal on behalf of the abovenamed patient.

_____
GIVEN NAME/S FAMILY NAME (BLOCK LETTERS) of person making appeal

of: _____
address of person making appeal

Signed: _____ Relationship to patient: _____ Date: | | | | | | | | |
eg. community visitor, spouse, friend etc.

Fax, mail or email your appeal to:

The Executive Officer
Mental Health Review Board
Level 30, 570 Bourke Street
Melbourne 3000

Telephone: **8601 5270**
Facsimile: **8601 5299**
Toll Free: **1800 242 703**
Email **mhrb@mhrb.vic.gov.au**

You may ask a member of staff at the service to send your appeal to the Board.

MHA 5 APPEAL TO MHRB

ROLLS FILING SYSTEMS (03) 8770 1111

OCT 2006

White - ADMIN (send/fax copy to MHRB) Yellow - PATIENT FILE Green - PATIENT/APPLICANT