NSW GOVERNMENT Health

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

Site:

APPLICATION TO MEDICAL SUPERINTENDENT FOR REVIEW OF DECISION OF AUTHORISED MEDICAL OFFICER

SMR025155

NSW DEPARTMENT OF HEALTH

MENTAL HEALTH ACT 2007
Section 11

APPLICATION FOR REVIEW OF DECISION OF AUTHORISED MEDICAL OFFICER

To, The Medical Superintendent

……
(Name of declared mental health facility)

I, …….. request review of the decision:
(Name of applicant in full)

☐ not to admit me as a voluntary patient

☐ not to admit as a voluntary patient ……..……
(Name in full)
for whom I am the appointed Guardian under section 14 of the Guardianship Act 1987

☐ to discharge me as a voluntary patient

☐ to discharge as a voluntary patient ……..……...
(Name in full)
for whom I am the appointed Guardian under section 14 of the Guardianship Act 1987

**** tick one box only***

I can be contacted in relation to this application on ……..
(telephone, fax or email address)

and/or by writing to ……..…….. .

Signature: ……..…….

Date: ……. 20 .

Holes punched as per AS2828-1999
BINDING MARGIN - NO WRITING

NH606703 - 070611

APPLICATION TO MEDICAL SUPERINTENDENT FOR REVIEW OF DECISION OF AUTHORISED MEDICAL OFFICER

SMR025.155