



FAMILY NAME		MRN
GIVEN NAME		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
D.O.B. ____/____/____	M.O.	
ADDRESS		
LOCATION / WARD		
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE		

Facility:

**FORM 3  
APPEAL BY PATIENT AGAINST  
REFUSAL TO DISCHARGE**

**Form 3**  
(Mental Health Regulation 2025, Clause 8(1)(a))  
(Mental Health Act 2007, Section 44 (2))  
**Appeal by Patient Against Refusal to Discharge**

The Registrar  
Mental Health Review Tribunal  
PO Box 2019  
BORONIA PARK NSW 2111

My name is .....

I am an involuntary patient / a person detained at .....  
(name of mental health facility)

I have applied to an authorised medical officer for discharge under section 42 (1) of the *Mental Health Act 2007*.

I want to appeal to the Mental Health Review Tribunal against the authorised medical officer's:

- refusal to discharge me
- failure to make a determination on my application for discharge within 3 working days after I made the application.

**(Tick one box only)**

.....  
[Signature]

..... / ..... / .....  
[Date]



SMR025120

Holes Punched as per AS2828.1: 2019  
BINDING MARGIN - NO WRITING

NH606708A 100326

**FORM 3 - APPEAL BY PATIENT  
AGAINST REFUSAL TO DISCHARGE**

SMR025.120