Application
Mental Health Act 2014 (WA)

Application for Review of an Order Restricting Freedom of Communication
s 427(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 Form 12 C Restriction on Freedom of Communication

Date order made:

Name of psychiatrist making the order: _____

Name of mental health service: _____

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

Signature Date

Please save the completed application and submit via the MHT's Document Lodgement Portal

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