# TRIBUNAL REVIEW REPORT

**Date:**

**TO: ACT CIVIL & ADMINISTRATIVE TRIBUNAL**

**ACATMentalHealth@act.gov.au**

**Regarding: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_**

**ADDRESS**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MENTAL ILLNESS OR MENTAL DISORDER**

The person has a mental illness Yes No and/or a mental disorder Yes No

**MENTAL ILLNESS OR MENTAL DISORDER** (Use the definitions set out in the glossary at the end of this form)

1. The person has a mental illness Yes No and/or a mental disorder Yes No

**For mental illness:** Describe how the illness impairs the person’s mental functioning, identify the areas of functioning that are affected by the illness and identify the symptoms that characterise the illness and/or the behaviour that may be taken to indicate the presence of one or more of the symptoms.

**For mental disorder:** Identify the disorder using the definition and describe how and to what degree the disorder affects the person

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ASSESSMENT (**Set out details of your assessment supporting your opinion.)

1. Date of most recent assessment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current presentation:

Mental State Examination including dates conducted:

Relevant past history:

**DECISION-MAKING CAPACITY**

1. Does the person, or can the person (with assistance if needed):
2. Understand when a decision about treatment, care or support needs to be made?

Yes No

1. Understand the facts that relate to the decision? Yes No
2. Understand the main choices? Yes No
3. Weigh up the consequences of the main choices? Yes No
4. Understand how the consequences affect the person? Yes No
5. On the basis of (a)-(e) make the decision? Yes No
6. Communicate the decision in whatever way the person can? Yes No

Describe and explain your overall assessment referring to the factors above and to the principles of decision-making capacity set out in section 8 (see Glossary):

**REFUSAL**

1. Does the person refuse to receive treatment, care or support; or, if the person has decision-making capacity, refuse to consent to treatment, care or support? Yes No

If yes, describe what the person does and/or says that constitutes refusal

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RISK OR DETERIORATION**

1. Is the person doing, or likely to do serious harm to themself or someone else because of the mental illness or mental disorder? Yes No

If yes, explain your reasons for this opinion.

Is the person suffering, or likely to suffer serious mental or physical deterioration because of the mental illness or mental disorder? Yes No

If yes, explain your reasons for this opinion.

**TREATMENT**

1. What treatment, care or support is proposed? *(If a treatment plan is prepared it may be attached to this form)*
2. Why or how will treatment care or support be likely to reduce harm, or deterioration, or result in an improvement to the person’s condition?
3. Why can’t the treatment care or support be adequately provided with less restriction of the freedom of choice and movement of the person?

**OPINION/RECOMMENDATIONS**

Overall opinion

I recommend an additional order be made Yes No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Full name of Applicant** (relevant official or delegate or nominee of the Chief Psychiatrist)

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Information sheet attached Yes No

Treatment plan, location determination form attached Yes No