


<b>File Number</b>  MH /	<p style="text-align: center;"><b>ACT CIVIL AND ADMINISTRATIVE TRIBUNAL</b></p> <p style="text-align: center;"><b>Application to review or extend consent to treatment, care or support</b></p>	
	<p style="text-align: center;">For use by health professional  <i>Guardianship and Management of Property Act 1991, Powers of Attorney Act 2006</i></p>	

**1. This application is about:**

Name: \_\_\_\_\_ Gender: \_\_\_\_\_ DOB: \_\_\_\_\_

(You must complete and attach the information sheet for further details)

**2. The application is made by:**

Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Position held: \_\_\_\_\_

**3. This application is for (tick applicable box):**

**Approval to continue providing treatment, care or support in accordance with the consent of a health attorney.**

The plan(s) for the treatment, care or support for which consent was initially given and which is proposed must be attached.

If the plan does not include the following information please state:

The name of the Health Attorney: \_\_\_\_\_

The date that consent was initially given: \_\_\_\_\_

The period for which approval is sought (not longer than 8 weeks after the end of the initial consent period) \_\_\_\_\_

OR

**Review of a consent for treatment given by a guardian or attorney**

The written consent that is to be reviewed must be attached together with a brief statement explaining why the applicant wants the consent to be reviewed.

**Signature of applicant:** \_\_\_\_\_

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

**Reminder: Attach Information Sheet**

**Attach Treatment Care or Support Plan**

**Attach Written Consent**