

application by a psychiatrist for the medical treatment of a patient with a psychiatric disability
GUARDIANSHIP AND ADMINISTRATION BOARD



the patient

Name _____

Address _____

_____ Postcode _____

Date of Birth (if known) _____ / _____ / _____

How long have you known the patient? _____

On what date did you last personally examine the patient?

Are you the patient's regular medical attendant? Please tick

Yes No

the person responsible

Name _____

Telephone _____

Address _____

_____ Postcode _____

Have you discussed the treatment with the person

responsible? Please tick Yes No

If yes, please provide brief details of the discussion:

details of the applicant

(psychiatrist)

Name _____

Address _____

_____ Postcode _____

Telephone (work) _____

(mobile) _____

Fax number _____

Email address _____

hearing

Does the application need to be heard urgently? Please tick

Yes No

If yes, please provide reasons, why allowing

10 days notice before the hearing would

not be in the best interests of the patient.

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List the relevant medication currently administered to this patient.

Please list any further reports/assessments/examinations that may assist the Board in determining this application.

Do you recommend any further tests or assessments be carried out in determining the patient's capacity? Please tick

Yes No

If yes, please specify the tests or assessments:

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interested parties

Please provide details of all other persons (regardless of their views) who might have an interest in this application and a concern for the patient's welfare.

Name _____

Address _____

_____ Postcode _____

Preferred Contact Telephone Numbers

Name _____

Address _____

_____ Postcode _____

Preferred Contact Telephone Numbers

Name _____

Address _____

_____ Postcode _____

Preferred Contact Telephone Numbers

Name _____

Address _____

_____ Postcode _____

Preferred Contact Telephone Numbers

orders sought

What is the treatment that you seek consent for (please be as specific as possible, eg name, dosage and duration of a drug or treatment)?

Details of Registered Practitioner who will carry out the treatment:

Name _____

Address _____

_____ Postcode _____

Telephone (work) _____

(mobile) _____

Fax Number _____

Email address _____

Date and place of treatment _____

Duration of the treatment _____

