



APPLICATION FOR DISPUTE RESOLUTION

Office of the Public Advocate - Dispute Resolution Service

For Office Use only	
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Client No	
Form Review Date	30/7/2018

APPLICATION FOR DISPUTE RESOLUTION

Advance Care Directives Act 2013

Consent to Medical Treatment and Palliative Care Act 1995

What is this form for?

Use this form to apply for Dispute Resolution.

- If the person has made an advance care directive and there is a disagreement about a health, accommodation or personal decision that has to be made for that person. This includes people who have made an Enduring Power of Guardianship, a Medical Power of Attorney or an Anticipatory Direction before July 1st 2014.
- If a person does not have an advance care directive, but there is a disagreement about health care and/or medical treatment. This includes disputes involving children under 16 years of age.

Who can Apply?

- the person who the decision is about (self)
- a substitute decision- maker appointed under an advance care directive
- If the matter relates to a child (under 16yrs) a parent or guardian of the child
- a relative of the person
- If the person is a patient with impaired decision making capacity in respect to a particular decision, a person responsible for the patient
- a health practitioner giving, or proposing to give health care to the person
- the person/people in charge of the day to day care of the person who made the ACD
- any other person who the Public Advocate assesses as having a proper interest in the life of the person and the dispute.

- **If the person themselves is making the application, skip section 2**

Lodging the application

If you require assistance a verbal application can be made over the phone or in person at the Office of the Public Advocate.

Mail	Office of the Public Advocate, PO Box 213, Prospect SA 5082
Email	opa@agd.sa.gov.au
Fax	08 8342 8250
Deliver	Level 7, ABC Building, 85 North East Road, Collinswood SA 5081

APPLICATION FOR DISPUTE RESOLUTION

Section 1

DETAILS OF THE PERSON WHO THE APPLICATION IS ABOUT

Title:	<input type="checkbox"/> Mr	<input type="checkbox"/> Mrs	<input type="checkbox"/> Ms	<input type="checkbox"/> Miss	<input type="checkbox"/> Dr	<input type="checkbox"/> Other
Surname:				First Name		
Current Address						
Suburb:						
State:			Postcode:			
Home Address (if different)						
Suburb:						
State:			Postcode:			
Email address:						
Contact Numbers	Daytime No:			Mobile No:		
Date of Birth:				Gender	<input type="checkbox"/> M	<input type="checkbox"/> F
Country of Birth:					Does the person need an interpreter	<input type="checkbox"/> Y <input type="checkbox"/> N
Does the person identify as Aboriginal or Torres Strait Islander	<input type="checkbox"/> Y	<input type="checkbox"/> N				
Are there cultural aspects to consider	<input type="checkbox"/> Y	<input type="checkbox"/> N				
Please specify:						
Has the person made an Advance care Directive	<input type="checkbox"/> Y	<input type="checkbox"/> N	If possible please provide a copy of this document			
Do you think the person has decision making capacity	<input type="checkbox"/> Y	<input type="checkbox"/> N	Have you informed the person about this application	<input type="checkbox"/> Y	<input type="checkbox"/> N	

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Section 2

APPLICANT DETAILS <i>Applicant 1</i>						
Title:	Mr <input type="checkbox"/>	Mrs <input type="checkbox"/>	Ms <input type="checkbox"/>	Miss <input type="checkbox"/>	Dr <input type="checkbox"/>	Other
Name:					Surname	
Postal Address						
Suburb						
State				Postcode:		
Email address						
Contact Numbers:	Daytime No:		Mobile No:			
Who referred you to the OPA service:						
Relationship to the person			Are you the Substitute Decision Maker		<input type="checkbox"/> Yes	<input type="checkbox"/> No
			Are you the Enduring Power of Attorney		<input type="checkbox"/> Yes	<input type="checkbox"/> No

APPLICANT DETAILS <i>Applicant 2 if required</i>						
Title:	Mr <input type="checkbox"/>	Mrs <input type="checkbox"/>	Ms <input type="checkbox"/>	Miss <input type="checkbox"/>	Dr <input type="checkbox"/>	Other
Name:					Surname	
Postal Address						
Suburb						
State				Postcode:		
Email address						
Contact Numbers:	Daytime No:		Mobile No:			
Who referred you to the OPA service:						
Relationship to the person			Are you the Substitute Decision Maker		<input type="checkbox"/> Yes	<input type="checkbox"/> No
			Are you the Enduring Power of Attorney		<input type="checkbox"/> Yes	<input type="checkbox"/> No

APPLICATION FOR DISPUTE RESOLUTION

Section 3

OTHER PEOPLE TO BE INCLUDED IN DISPUTE RESOLUTION						
Title:	Dr <input type="checkbox"/>	Mr <input type="checkbox"/>	Mrs <input type="checkbox"/>	Ms <input type="checkbox"/>	Miss <input type="checkbox"/>	Other
Name:				Surname		
Address						
Suburb:						
State:			Postcode:			
Email address						
Contact numbers:	Daytime No:		Mobile No:			
Relationship to the person			Are they the Substitute Decision Maker <input type="checkbox"/> Yes <input type="checkbox"/> No Are they the Enduring Power of Attorney <input type="checkbox"/> Yes <input type="checkbox"/> No			
Have they been informed of the application:				<input type="checkbox"/> Yes		<input type="checkbox"/> No
Title:	Dr <input type="checkbox"/>	Mr <input type="checkbox"/>	Mrs <input type="checkbox"/>	Ms <input type="checkbox"/>	Miss <input type="checkbox"/>	Other
Name:				Surname		
Address						
Suburb:						
State:			Postcode:			
Email address						
Contact Numbers:	Daytime No:		Mobile Np:			
Relationship to the person			Are they the Substitute Decision Maker <input type="checkbox"/> Yes <input type="checkbox"/> No Are they the Enduring Power of Attorney <input type="checkbox"/> Yes <input type="checkbox"/> No			
Have they been informed of the application:				<input type="checkbox"/> Yes		<input type="checkbox"/> No

APPLICATION FOR DISPUTE RESOLUTION

Title:	Dr <input type="checkbox"/>	Mr <input type="checkbox"/>	Mrs <input type="checkbox"/>	Ms <input type="checkbox"/>	Miss <input type="checkbox"/>	Other
Name:				Surname		
Address						
Suburb:						
State:			Postcode:			
Email address						
Contact Numbers:	Daytime No:		Mobile:			
Relationship to the person:			Are they the Substitute Decision Maker <input type="checkbox"/> Yes <input type="checkbox"/> No Are they the Enduring Power of Attorney <input type="checkbox"/> Yes <input type="checkbox"/> No			
Have they been informed of the application:			<input type="checkbox"/> Yes		<input type="checkbox"/> No	
Title:	Dr <input type="checkbox"/>	Mr <input type="checkbox"/>	Mrs <input type="checkbox"/>	Ms <input type="checkbox"/>	Miss <input type="checkbox"/>	Other
Name:				Surname		
Address						
Suburb:						
State:			Postcode:			
Email address						
Contact Numbers:	Daytime No:		Mobile No:			
Relationship to the person			Are they the Substitute Decision Maker <input type="checkbox"/> Yes <input type="checkbox"/> No Are they the Enduring Power of Attorney <input type="checkbox"/> Yes <input type="checkbox"/> No			
Have they been informed of the application:			<input type="checkbox"/> Yes		<input type="checkbox"/> No	

APPLICATION FOR DISPUTE RESOLUTION

Title:	<input type="checkbox"/> Dr	<input type="checkbox"/> Mr	<input type="checkbox"/> Mrs	<input type="checkbox"/> Ms	<input type="checkbox"/> Miss	Other
Name:				Surname		
Address						
Suburb:						
State:			Postcode:			
Email address						
Contact Numbers:	Daytime No:		Mobile No:			
Relationship to the person:			Are they the Substitute Decision Maker <input type="checkbox"/> Yes <input type="checkbox"/> No Are they the Enduring Power of Attorney <input type="checkbox"/> Yes <input type="checkbox"/> No			
Have they been informed of the application:				<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Title:	<input type="checkbox"/> Dr	<input type="checkbox"/> Mr	<input type="checkbox"/> Mrs	<input type="checkbox"/> Ms	<input type="checkbox"/> Miss	Other
Name:				Surname		
Address						
Suburb:						
State:			Postcode:			
Email address						
Contact Numbers:	Daytime No:		Mobile No:			
Relationship to the person			Are they the Substitute Decision Maker <input type="checkbox"/> Yes <input type="checkbox"/> No Are they the Enduring Power of Attorney <input type="checkbox"/> Yes <input type="checkbox"/> No			
Have they been informed of the application:				<input type="checkbox"/> Yes	<input type="checkbox"/> No	

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Section 4

Do you think the person is able to take part in the dispute resolution process /mediation?

Yes No **Please specify:** _____

Are there any safety concerns for any of the parties attending mediation? If so please give details (e.g. physical safety / verbal abuse / threats from anyone attending the mediation)

Will the person require any special assistance to be involved in the dispute resolution process:

wheelchair / mobility access for vision impairment / loss
 hearing impairment /loss other (please specify below)
 for speech impairment _____

Details of issues that are in dispute:
