For Office Use only	
Received Date	
Client No	
Correspondence No	

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 mediation to resolve disputes

- 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
- 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, begin at section 2**

Lodging the application

If you require assistance a verbal application can be take 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**

Telephone (08) 8342 8200 **Tollfree SA Country 1800 066 969**

APPLICATION FOR DISPUTE RESOLUTION

Section 1

APPLICANT DETAILS						
Title:	Mr ☐	Mrs ☐	Ms ☐	Miss ☐	Dr ☐	Other
Name:				First Name		
Postal Address						
Suburb						
State			**Postcode:**			
Email address						
Telephone number:	**Home:**		**Work:**		**Mobile:**	
Who referred you to the OPA service:						
Relationship to the person						
Signature of Applicant						

Section 2

DETAILS OF THE PERSON WHO THE APPLICATION IS ABOUT						
Title:	Mr ☐	Mrs ☐	Ms ☐	Miss ☐	Dr ☐	Other
Name:			First Name			
Current Address						
Suburb:						
State:		**Postcode:**				
Home Address						
Suburb:						
State:		**Postcode:**				
Contact numbers:	**Home:**		**Work:**		**Mobile:**	
Email address:						
Date of Birth:				**Gender**	M ☐	F ☐
Has the person made an Advance care	Y☐	N ☐	**If so please provide date**			

directive				
Areas of authority of the Advance Care Directive:	Health ☐ Accommodation ☐ Personal Details ☐			
Have you informed the person about this application	☐ Yes – how did they respond (please describe briefly) ☐ No – why not? (please describe briefly)			
Does the person identify:	☐ Aboriginal	☐ Torres Strait Islander		
What is the person's country of birth?				
Are there any cultural aspects to be considered				
Will the person require any special assistance to be involved in the dispute resolution process: ☐ wheelchair / mobility access ☐ hearing impairment /loss ☐ interpreter ( ) *Please specify language* ☐ for speech impairment ☐ for vision impairment / loss ☐ other (please specify below)				

Do you think the person is able to take part in the dispute resolution process /mediation? Please explain why/why not

Details of issues that are in dispute

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)

Section 3

DETAILS OF ANY SUBSTITUTE DECISION MAKER(S) THROUGH AN ADVANCE CARE DIRECTIVE						
Title:	Dr ☐	Mr ☐	Mrs ☐	Ms ☐	Miss ☐	Other
Name:			First Name			
Address						
Suburb:						
State:		**Postcode:**				
Email address						
Telephone number:	**Home:**	**Work:**	**Mobile:**			
Relationship to the person						
Have they been informed of the application:	☐ Yes	☐ No				
Title:	Dr ☐	Mr ☐	Mrs ☐	Ms ☐	Miss ☐	Other
Name:			First Name			
Address						
Suburb:						
State:		**Postcode:**				
Email address						
Telephone number:	**Home:**	**Work:**	**Mobile:**			
Relationship to the person						
Have they been informed of the application:	☐ Yes	☐ No				

DETAILS OF ANY SUBSTITUTE DECISION MAKER(S) THROUGH AN ADVANCE CARE DIRECTIVE continued						
Title:	Dr ☐	Mr ☐	Mrs ☐	Ms ☐	Miss ☐	Other
Name:			First Name			
Address						
Suburb:						
State:		**Postcode:**				
Email address						
Telephone number:	**Home:**		**Work:**		**Mobile:**	
Relationship to the person						
Have they been informed of the application:		☐ Yes		☐ No		
Title:	Dr ☐	Mr ☐	Mrs ☐	Ms ☐	Miss ☐	Other
Name:			First Name			
Address						
Suburb:						
State:		**Postcode:**				
Email address						
Telephone number:	**Home:**		**Work:**		**Mobile:**	
Relationship to the person						
Have they been informed of the application:		☐ Yes		☐ No		

Section 4

OTHER PEOPLE TO BE INCLUDED IN DISPUTE RESOLUTION						
Title:	Dr ☐	Mr ☐	Mrs ☐	Ms ☐	Miss ☐	Other
Name:			First Name			
Address						
Suburb:						
State:		**Postcode:**				
Email address						
Telephone number:	**Home:**	**Work:**	**Mobile:**			
Relationship to the person						
Have they been informed of the application:	☐ Yes	☐ No				
Title:	Dr ☐	Mr ☐	Mrs ☐	Ms ☐	Miss ☐	Other
Name:			First Name			
Address						
Suburb:						
State:		**Postcode:**				
Email address						
Telephone number:	**Home:**	**Work:**	**Mobile:**			
Relationship to the person						
Have they been informed of the application:	☐ Yes	☐ No				

Title:	Dr ☐	Mr ☐	Mrs ☐	Ms ☐	Miss ☐	Other
Name:			First Name			
Address						
Suburb:						
State:		**Postcode:**				
Email address						
Telephone number:	**Home:**	**Work:**	**Mobile:**			
Relationship to the person who made the Advance Care Directive:						
Have they been informed of the application:	☐ Yes	☐ No				

Title:	Dr ☐	Mr ☐	Mrs ☐	Ms ☐	Miss ☐	Other
Name:			First Name			
Address						
Suburb:						
State:		**Postcode:**				
Email address						
Telephone number:	**Home:**	**Work:**	**Mobile:**			
Relationship to the person						
Have they been informed of the application:	☐ Yes	☐ No				

Title:	Dr ☐	Mr ☐	Mrs ☐	Ms ☐	Miss ☐	Other
Name:			First Name			
Address						
Suburb:						
State:		**Postcode:**				
Email address						
Telephone number:	**Home:**	**Work:**	**Mobile:**			
Relationship to the person						
Have they been informed of the application:	☐ Yes	☐ No				

Title:	Dr ☐	Mr ☐	Mrs ☐	Ms ☐	Miss ☐	Other
Name:			First Name			
Address						
Suburb:						
State:		**Postcode:**				
Email address						
Telephone number:	**Home:**	**Work:**	**Mobile:**			
Relationship to the person						
Have they been informed of the application:	☐ Yes	☐ No				