



# 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	30/06/2019

## 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.

<b>Mail</b>	<b>Office of the Public Advocate, GPO Box 464, Adelaide SA 5001</b>
<b>Email</b>	<b>opa@agd.sa.gov.au</b>
<b>Fax</b>	<b>08 8429 6121</b>
<b>Deliver</b>	<b>Shop 1. 211 Victoria Square, Adelaide 5000</b>

# APPLICATION FOR DISPUTE RESOLUTION

## Section 1

### DETAILS OF THE PERSON WHO THE APPLICATION IS ABOUT

Title:	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	M <input type="checkbox"/>	F <input type="checkbox"/>
Country of Birth:	Click or tap here to enter text.				Does the person need an interpreter	Y <input type="checkbox"/> N <input type="checkbox"/>
Does the person identify as Aboriginal or Torres Strait Islander	Y <input type="checkbox"/>	N <input type="checkbox"/>				
Are there cultural aspects to consider	Y <input type="checkbox"/>	N <input type="checkbox"/>				
Please specify:						
Has the person made an Advance care Directive	Y <input type="checkbox"/>	N <input type="checkbox"/>	If possible please provide a copy of this document			
Do you think the person has decision making capacity	Y <input type="checkbox"/>	N <input type="checkbox"/>	Have you informed the person about this application		Y <input type="checkbox"/> N <input type="checkbox"/>	

# APPLICATION FOR DISPUTE RESOLUTION

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

## APPLICATION FOR DISPUTE RESOLUTION

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

## APPLICATION FOR DISPUTE RESOLUTION

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



