

4 DETAILS OF RELATIVES OR FRIENDS INVOLVED WITH THIS PERSON

Details of any known relatives or friends currently involved with this person. It is necessary for you to contact the relatives or friends and discuss this application with them.

Name	Relationship	Phone Number

Detail of Contact

5 REASONS FOR MAKING EMERGENCY GUARDIANSHIP APPLICATION

What are your reasons for making this emergency guardianship application? Please include a clear description of the emergency decision/s that is required:

6 TIME AND DATE

Please indicate the time and date you informed the person subject to this application that you are applying for emergency orders:

Time _____

Date ____ / ____ / ____

7 DETAILS OF PERSON MAKING APPLICATION

Full Name of person making application _____
(Please print)

Contact Telephone Number _____

Facsimile Number _____

Relationship to person subject of this application _____

Signature of person making application: _____

Date ____ / ____ / ____

For further advice/support:-

PUBLIC TRUSTEE AND GUARDIAN

PO Box 221
Civic Square ACT 2608

Telephone: (02) 6207 9800
Facsimile: (0) 6207 9811

Email: guardians@act.gov.au
Website: www.ptg.act.gov.au



**PUBLIC TRUSTEE
AND GUARDIAN**



MEDICAL REPORT FOR THE APPOINTMENT OF AN EMERGENCY GUARDIAN



1 DETAILS OF PERSON SUBJECT TO THIS APPLICATION

Hospital Number: _____
Full Name _____ Date of Birth ____/____/____

2 GUARDIANSHIP DECISIONS

Please state clearly the guardianship decisions that are required:

3 IMPAIRED DECISION-MAKING CAPACITY

Please state clearly what impaired decision-making capacity the person has that prevents them making decisions in relation to their health and welfare:

4 DOCTORS CONTACT DETAILS

Name of doctor preparing medical report: _____
(Please print)

Contact Telephone Number of Doctor preparing medical report:

Signature of Doctor: _____ Date ____/____/____