**Submission form for victims of special patients**

**Important note – this information will *not* be shared with the special patient**

If you would like help writing your submission, please contact Manaaki Tāngata Victim Support on 0800 842 846. Their services are free, confidential, and available 24/7. Their full contact details can be found at [victimsupport.org.nz.](https://www.victimsupport.org.nz/contact-us/our-contact-details)

**1. Which of the following phrases best describes you:**

|  |  |
| --- | --- |
| £ | I am a victim of the special patient named below |
| £ | I am the parent/legal guardian of the victim of the special patient named below  |
| £ | I am the representative of the victim of the special patient named below |
| £ | Other |
|  |  |
| **2. Concern you have about the special patient/ special care recipient being granted leave** Please detail your opinion on the application that has been made. Do you have any concerns about this application being granted?Click or tap here to enter text. |
| **3. Information about the risk the special patient presents to you, your immediate family/ whānau, or the community’s psychological and/ or physical safety or security**Please talk about any risk to your or your immediate family/whānau psychological and/ or physical safety and security.Click or tap here to enter text. |
| **4. Are there any conditions of leave that would help you feel safe?**Detail any conditions of leave, and the reason for giving them, that would help you feel safe. This may include a condition such as they do not visit a certain place or recreational area.Click or tap here to enter text. |
| **5. Other information**Include any other information you think would be useful for the Director of Mental Health when deciding to approve the application.Click or tap here to enter text. |

I understand that the person named as the special patient at the end of this form will not be able to read a copy of this submission. I understand that this information will be shared with the Director of Mental Health, the Director of Area Mental Health Services and professionals involved in the decision making process.

|  |  |  |  |
| --- | --- | --- | --- |
| **Signed** |  | Date |  |

**Please send to:** Click or tap here to enter text.

**Name of special patient who offended against you**

|  |  |
| --- | --- |
| Name: | Click or tap here to enter text. |