



# Psychiatric Patient Advocate Office

## Request for Rights Advice Visit

Request Date & Time: \_\_\_\_\_  
day/month/year                      time

Request made by:  Telephone                       Fax

### Part 1 – Hospital Contact Information

Hospital: \_\_\_\_\_

Site: \_\_\_\_\_

City/Town: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Tel: \_\_\_\_\_ Pager: \_\_\_\_\_  
(area code, number & extension)                      (if any)

### Part 2 – Identification of person to receive rights advice

Name: \_\_\_\_\_ Casebook #: \_\_\_\_\_  
(first name)                      (last: initial)

Location: \_\_\_\_\_ OR \_\_\_\_\_  
(inpatient unit & room)                      (home address, if applicable – i.e., Form 24 or Community Treatment Order)



Communication Needs: \_\_\_\_\_  
(e.g., interpreter language)

### Part 3 – Rights advice required:

- |                                  |   |
|----------------------------------|---|
| <input type="checkbox"/> Form 3  | <input type="checkbox"/> Form 27                  |
| <input type="checkbox"/> Form 4  | <input type="checkbox"/> Form 33 <b>treatment</b> |
| <input type="checkbox"/> Form 21 | <input type="checkbox"/> Form 33 <b>records</b>   |
| <input type="checkbox"/> Form 24 | <input type="checkbox"/> Form 49                  |

\_\_\_\_\_  
Form #s                      Signed (day / month / year)                      Form #s                      Signed (day / month / year)

### Instructions

1. Indicate date and time of your request.
2. Identify hospital fully in Part 1.
3. Identify the person to receive rights advice in Part 2. Indicate any communication needs.
4. Identify the rights advice issues(s) in Part 3. Indicate date each Form was signed at the bottom of Part 3.
5. **After you have completed this request form:**  
fax it to the PPAO intake office at  
 **1-866-822-2333 or 416-314-4484 local**  
 **and/or call 1-866-851-1212 416-327-8240 local**  
and leave all the information.
6. Place this *request form* in the PPAO blue binder, with a copy of each **notice to the patient** attached. Include a copy of a 'treatment plan' if *Form 49* issued.

### For PPAO Office Use only

Intake \_\_\_\_\_  
Date                      Time

R A \_\_\_\_\_  
Name

Assigned \_\_\_\_\_  
Date                      Time

Rights Advice Completion Confirmed:

\_\_\_\_\_  
Date                      Time

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