

## MONTHLY RIGHTS ADVICE DATA

Psychiatric Facility Name: \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_

Postal Code \_\_\_\_\_

Month/Year \_\_\_\_\_

RIGHTS ADVICE SITUATIONS	First Contact	2 <sup>nd</sup> Contact	3 <sup>rd</sup> & Subsequent Contacts	Application to Consent & Capacity Board	Rights Advice Duration		CCB Hearing		Outcome of Hearing Patient Successful		Reason No Hearing Held		
					<30 Mins	>30 Mins	Yes	No	Yes	No	Physician changed status (e.g. issued Form 5) Col. K	Patient Withdrew Application Col. L	Other Col. M
	Col. A	Col. B	Col. C	Col. D	Col. E	Col. F	Col. G	Col. H	Col. I	Col. J			
<b>MENTAL HEALTH ACT</b>													
<b>Form 3</b> (involuntary admission) (notice Form 30)	20	10	2		32								
<b>Form 4</b> (involuntary admission renewal) (notice Form 30)	5			1	4	1		1			1		
<b>Form 21</b> (capacity to manage property) (notice Form 33)	2				2								
<b>Form 24</b> (capacity to manage property; continuance) (notice Form 33)													
<b>Form 27</b> (12-15 years old informal admission)													
<b>Notice Form 33</b> (incomp. re. disclose clinical record)													
<b>Notice Form 33</b> (incomp. re. examine clinical record)													
<b>Notice Form 49</b> (issuance of Community Treatment Order)													
<b>Notice Form 49</b> (Renewal of CTO)													
<b>HEALTH CARE CONSENT ACT</b> (Notice of Rights MHA F.33) (Treatment incapacity)	3	1			2	2							
<b>SUB-TOTAL</b>	30	11	2	1	40	3		1			1		
<b>GRAND TOTAL</b>	43			1	43		1		1				

 Completed by: \_\_\_\_\_ Phone # \_\_\_\_\_  
 (please print)

Please mail completed form to : Psychiatric Patient Advocate Office, 55 St. Clair Avenue West, Box 28, Suite 802, Toronto ON M4V 2Y7  
 Please contact Linda Carey at (416) 327-7001 or toll free 1(800)578-2343 for any assistance in completing this form.  
 This form is available on the PPAO's website at [www.ppaos.gov.on.ca](http://www.ppaos.gov.on.ca)