NOVA SCOTIA
Health and Wellness

Mental Health Patient Advisor Service

Request for Rights Advice Visit

Request Date & Time: _____ _____
Day/month/year *time*

Request made by: _____
Name

Fax ☐ Electronic Form ☐

Instructions

1. Indicate date and time of your request
2. Identify hospital/site fully in Part 1.
3. Identify the person to receive rights advice and indicate any communication needs Part 2.
4. Check rights advice issues(s) in Part 3. **Fax** completed form to the PRAS office at:
   (902) 404-9020
   or
   PRASAdmin@novascotia.ca
5. Patient advisor to sign, date and note time rights advice given.

PART 1: CONTACT INFORMATION

Hospital/Site: _____

Contact Person: _____

Telephone/Cell: _____ **Pager:** _____
(area code, number & extension) *(If any)*

PART 2: PATIENT INFORMATION

Patient: _____ **Patient Phone:** _____ **Patient Identifier #:** _____

Location: _____ **Patient Rights Advisor Service #** _____

Communication Needs: _____
(e.g., interpreter language)

Substitute Decision Maker:

_____ _____ _____
Name *Relationship* *Phone #*

PART 3: RIGHTS ADVICE REQUIRED DUE TO

☐	**Change of Status to Voluntary**	☐	**Declaration of Involuntary Admission**
☐	**Certificate of Leave**	☐	**Community Treat Order**
☐	**Declaration of Renewal**	☐	
Review Board: ☐ Request ☐ Automatic			

PART 4: TO BE COMPLETED BY PATIENT RIGHTS ADVISOR

Rights Provided to Patient			**Provided to Substitute Decision Maker**		
☐ ***In person***	☐ **By phone**	☐ **Refused Service**	☐ ***In person***	☐ **By phone**	☐ **Refused Service**
Rights advice provided by:			**Rights advice provided by:**		
Name:			**Name:**		
Date:			**Date:**		
Time:			**Time:**		