ADVOCACY FORMS

Form 1 - Alliance Advocacy Intake: Information and Referral

This form is used when upon a visit to a patient the patient asks us to do something specific for him or her. We put a referral number on it (start with #1 and from then on go in consecutive order with each new report). Then go along form and check appropriate information and fill in where necessary. Patient name is usually not put on this form.

Form 2 - Advocate Report Form

Place would be the hospital name; location would be the unit number. Referral number is the same one you used on intake form (form #1). The rest of the form is self-explanatory -- just fill in.

Form 2A- Write follow up at top of Advocate Report Form. Then fill in date, client's name, advocate's name. In nature of consultation area, put an update from original report. (Example - Patient has met with his doctor and passes have been granted -- if this was a pass problem). You usually don't have to fill in Plan of Action on this follow-up form and you don't have to sign. This form is used after weekly visits to patient.

Form 3 - Discharge form to Director - This form is for a voluntary patient. Fill in name, date and time. Have patient sign and you sign witness line. We then take it to the Secretary's office where he or she makes copies for doctor and therapist and for us. Original copy goes to Medical Records. Copy is taken to the Director's office. Patient should be released after 72 hours.

Form 4 - Discharge and Court Hearing form to Director - This form is for an involuntary patient who wants to be released. Fill in patient's name, then date and time. Have patient sign and you witness it. We then take it to Secretary's office where copies are made for doctor, therapist, us and Mental Hygiene Legal Services. Original goes to Medical Records. Copy is taken to the Director's office. After MHLS receives form, a lawyer visits patient and discusses situation with him. If they decide on going to court, the lawyer will have case put on court calendar and a date will be set for patient to go into court with MHLS lawyer. Alliance advocates attend the court hearings.

Form 5 - Request to Examine Clinical Records to Director - Fill in patient's name and date. Have the patient sign. Take to Director's office and copy to Medical Records.

Form 6 - Consent for Release of Information - This form is used when specific information is needed from the patient - ex. a copy of his or her's forensic records. Fill in blanks with necessary information. Have patient sign and have witnessed by a nurse or therapy aide. Take original copy to Medical Records. They should then arrange for you to get a copy through Mental Hygiene Legal Services attorney. There is a Refusal to Release Information on page 2, which the patient may opt to sign if they don't want the information released to us.

Form 7 - This is an Internal form used at Hutchings for its Advocacy Office. Have patient describe complaint and fill in. Patient should then give you information to fill in for 2 and 3. Have patient sign on line 4. Advocate signs at Enrollee Name and and give address. Relationship to an enrollee should read Patient/Advocate. This form has been used to report patient abuse. We then deliver form to Hutching's Advocacy Office and follow up abuse complaint with calls to the investigator there and our liaison. These forms are found on the units where patients can fill in on their own and place in box next to forms.

Rosemary L. Palermo
Advocacy Coordinator

RLP

7-10-96

(1)

ALLIANCE ADVOCACY INTAKE: INFORMATION AND REFERRAL

1. Referral number plus advocate's initials _____

2. Date _____

3. Time _____

4. Caller (name optional) _____
   Male _____ Female _____ Unreported _____

5. Relationship: a. Self _____ b. Friend _____ c. Relative _____
   d. Other (specify) _____

6. Concerning: Male _____ Female _____ Unreported _____

7. Age: Under 18 _____ 18-20 _____ 21-35 _____ 35-54 _____
   55 & over _____ Unreported _____

8. Request for: Advocacy _____ Information _____ Referral _____

9. Location of client: Syracuse _____ Onondaga County _____
   New York State (specify town, county) _____
   _____
   Out of state _____ Unreported _____

10. Residence of client

Independent _____	Halfway house _____
Parental, family home _____	Foster care _____
Public psychiatric facility _____	Nursing home _____
Private psychiatric facility _____	Educational institution___
Prison _____	Other _____
Shelter/transitional living _____	Unreported _____

11. Advocacy concern: Rights issues

Release _____	Free association and communication _____
Commitment _____	Rights notification/other info _____
Quality of care _____	Due process (grievance, hearing)____
Guardianship/payee _____	Criminal justice/forensic issue ____
Records/confidentiality _____	Inappropriate staff behavior___
Threats/intimidation _____	Treatment plan/discharge plan____
Emergency forced treatment _____	Treatment environment _____
Medication/treatment issues ___	Abuse/neglect/expolitation___
Refusal/lack of treatment ___	Other _____

12. Advocacy concern: Community issues

Transportation _____	Income/financial issues _____
Work/employment _____	Education/job training _____
Family/personal issues _____	Support/therapy issues _____
Housing/homelessness _____	Other _____

(2)

Advocate Report Form

Place:

Location:

Date:

Time:

Referral #:

Client's name:

Advocate's name(s):

Nature of Consultation:

Plan of Action/Action Taken:

Signature of Advocate(s) _____

_____

Date: _____

Form - P

(2A)

Advocate Report Form

Place:

Location:

Date:

Time:

Referral #:

Client's name:

Advocate's name(s):

Nature of Consultation:

Plan of Action/Action Taken:

Signature of Advocate(s) _____

_____

Date: _____

(3)

Bryan Rudes, Director
Hutchings Psychiatric Center
629 Madison Street
Syracuse, New York 13210

I, _____ , on _____ , request to be discharged. I wish the process to be started immediately.

TIME:_____

_____
signature

_____
witness

(4)

Bryan Rudes, Director
Hutchings Psychiatric Center
629 Madison Street
Syracuse, New York 13210

I, _____, on _____, request to be discharged immediately. I would like to have a court hearing to accomplish this as it is my right under the law. I wish the process to be started immediately.

Time:_____

_____
signature

_____
witness

cc: Mental Hygiene Legal Service

(5)

Bryan Rudes
Director
Hutchings Psychiatric Center
629 Madison Street
Syracuse, New York 13210

Dear Bryan Rudes:

I, _____, on _____,
request to examine my clinical records. Please respond to my request within ten days, as required by New York State Mental Hygiene Law section 33.16.

Sincerely,

Form OMH 11 (5-87)

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CONSENT FOR RELEASE OF INFORMATION

See Reverse Side for Instructions

Part I — Consent To Release Information

Extent or Nature of Information to be Disclosed

Purpose or Need for Information

From: Name, Address and Title of Person/Organization/Facility/Program Disclosing Information	**To:** Name, Address and Title of Person/Organization/Facility/Program to Which Disclosure Is To Be Made

A I Hereby Authorize the One-time Release of the Above Information to the Person/Organization/Facility/Program Identified Above. I Understand that the Information to be Released is Confidential and Protected from Disclosure. I also Understand that I Have the Right to Cancel My Permission to Release Information at any Time.

My Consent to Release Information Will Expire When Acted Upon, or 90 Days From this Date, Whichever Occurs First.

Signature of Patient/Person Acting for Patient	Relationship	Date Signed	Signature of Witness	Title	Date Signed

B I Hereby Authorize the Periodic Release of the Above Information to the Person/Organization/Facility/Program Identified Above as Often as Necessary to Plan For/Provide Care and Treatment. I Understand that the Information to be Released is Confidential and Protected from Disclosure. I also Understand that I Have the Right to Cancel My Permission to Release Information At Any Time.

My Consent to Release Information to the Person/Organization/Facility/Program Identified Above, Will Expire When I am no longer Receiving Services from such Person/Organization/Facility/Program, or One Year from this Date, Whichever Occurs First.

Signature of Patient/Person Acting for Patient	Relationship	Date Signed	Signature of Witness	Title	Date Signed

Record of Information Released

Signature of Staff Person Releasing Information	Title	Date Released

☐ I Hereby Cancel My [illegible] ...dicated in Part I to the Person/Organization/Facility/Program whose Name and Address is:

Indicated in Part I to the Person/Organization/Facility/Program whose Name and Address is:

Signature of Patient/Person Acting for Patient	Relationship	Date Signed	Signature of Witness	Title	Date Signed

(Use this space if additional room is needed to complete any of the items on the reverse side)

- INSTRUCTIONS -

1. Patient Signs A , if the Release of Information is for a Single Event.
2. Patient Signs B , if Information is to be Released Periodically during an episode of treatment
3. If the patient is under 18 years of age, only the responsible parent, relative or guardian must sign
   Exception If patient is a Voluntary Admission on own application, at least 16 years of age but under 18 years of age, only the patient must sign

For Advocacy Office use only:

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H.P.C. PMHP Form No:_____
Classification:_____

In order to help us review your complaint, please provide the following information. Please use your own words, and take whatever time you need. If you need assistance, please notify the Advocacy Office at 473-4980 ext. 7538 or 7539. Please place this form in the box provided after you have completed it.

Thank you.

1. Please describe your complaint:_____

_____

_____

_____

_____

_____

2. Have you spoken to anyone else, for example your Personal Services Coordinator, therapist, or another individual regarding this complaint?
YES____ **No**____ **If YES, who?**_____

What did they say or do?_____

_____

_____

3. What do you think should be done about this situation?_____

_____

_____

_____

_____

_____

(If you need more room, please use other side)

4. Your Name: _____
Your Address:_____**Phone no.**_____

Relationship to an enrollee: _____

Enrollee's Name (if not complainant):_____
Enrollee's Address:_____**Phone no.**_____

Received by:_____ Date:_____
Time:_____

F:\WP5.1\PMHP.COM