RAMA DE-ADDICTION & REHABILITATION CENTRE

MENTAL HEALTH ESTABLISHMENT

41 B, Asola, Fatehpur Beri, New Delhi-110074

Ph. No.: 9654855092, Email :ramadeaddictioncentre@gmail.com

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ADMISSION RECORD FORM

Regn. No. / UID No.	IP No.	Ward & Unit
Patient's Name	Age & Sex	Father's/Husband's Name
Education	Marital Status	Occupation
Religion	Monthly Income	Domicile

Permanent Address : Tel. No. :	Present Address : Tel No. :
I/D Marks : 1. 2.	3.Aadhar Details :
Admission Details :	Discharge Details :
DOA :	DOD :
Time :	Time :
Under Section :	Duration of Stay :
Admission (Provisional) Diagnosis(s)	Diagnosis (with ICD Code)
Admitting SR :	Discharging SR :
Admitting / Ward Consultant :	Discharging Consultant :
M.O.I./c	M.O.I./c

Referred By	1. Direct		2. Family	3. Othres	
Type of Discharge	1. Voluntary (Sec. 88, MHA 2017) 2. On request / Against Advice / Abscond / Escape (Sec. 98, MHA 2017) 3. Transfer (Sec. 93 MHA 2017)				
Status of Discharge	Recovered	Much improved	Minimally Improved	Unchanged	Dead
Cause of Death (if Applicable)					Autopsy YES / No

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ASSESSMENT OF CAPACITY

1. ***Definition and general principles :***

   Mental Healthcare: Section 2 (O) includes analysis and diagnosis of a person's mental condition and treatment as well as care and rehabilitation of such person for his mental illness or suspected mental illness.

   Capacity: Ability to take decision at the time it needs to be taken. It is decision specific and time specific.

   Past treatment or hospitalization shall not by itself justify any present or future determination of person's Mental Illness *(Chapter II, sec 3(4), MHA, 2017).*

   Determination of a person's mental illness shall alone not imply or to be taken to mean that the person is of unsound mind unless he is declared as such by a competent court *(Chapter II, sec 3(4), MHA, 2017)*

2. ***Reasons for doubting Capacity of the person (document symptoms and signs)***

   I.

   II.

3. ***Two staged process of MHC assessment :***

S. No.	Test	Yes / No
1.	**Test of diagnosis :**	
(i)	Does the person have an impairment or disturbance in functioning (Permanent or temporary)	
(ii)	Does the impairment or disturbance mean that the person is unable to make specific decisions when they need to?	
2	**Test of functionality :**	
(i)	Patient understands that he/she is ill.	
(ii)	Patient understands that he/she requires treatment.	
(iii)	Patient understands that the treatment would be best administered in Hospital setting.	
(iv)	Patient understand that there is a significant risk in taking treatment on OPD basis	
(v)	All possible help and support have been provided to make the patient understand the decision.	
(vi)	The information has been explained to the patient in a safe and comfortable setting.	
(vii)	Patient understand that taking the decision would mean taking medication for the illness and would need to stay in hospital for the same.	
(viii)	Patient has been given adequate time to think over the decision and discuss with his family.	

All information has been communicated to the patient in the language that he/she understands. It has been concluded that patient is ***having capacity / does not have capacity*** to make mental healthcare treatment decisions.

Date :

Time : **Mental Health Professional**

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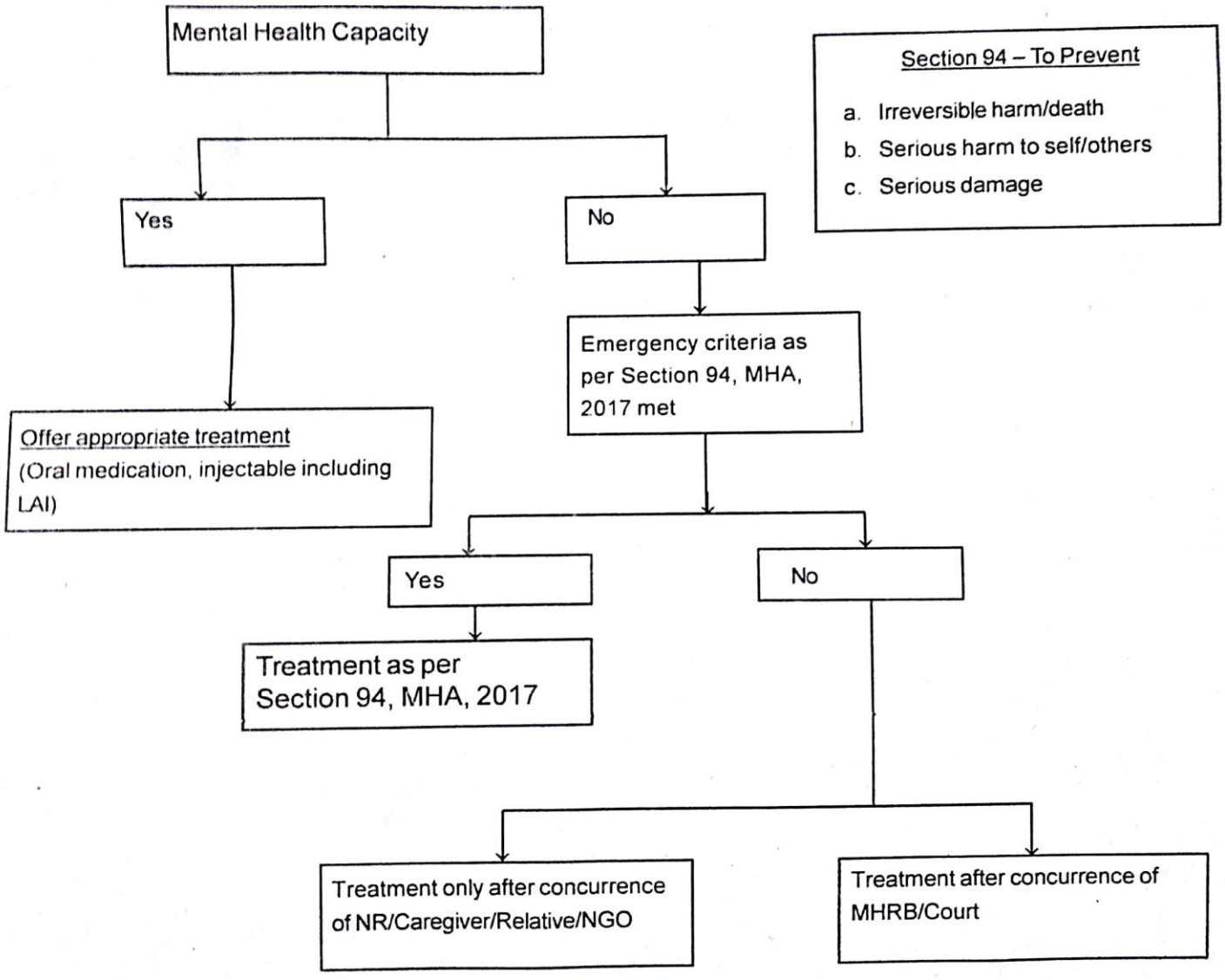
ALGORITHM FOR EMERGENCY TREATMENT

Name …….Age ……..Sex……..

U.I.D. No……..

ALGORITHM FOR NEED FOR EMERGENCY TREATMENT



Does the patient require hospitalization? – Yes / No

If Yes, the Section of Admission is _____

Date : **Signature of Mental Health Professional**

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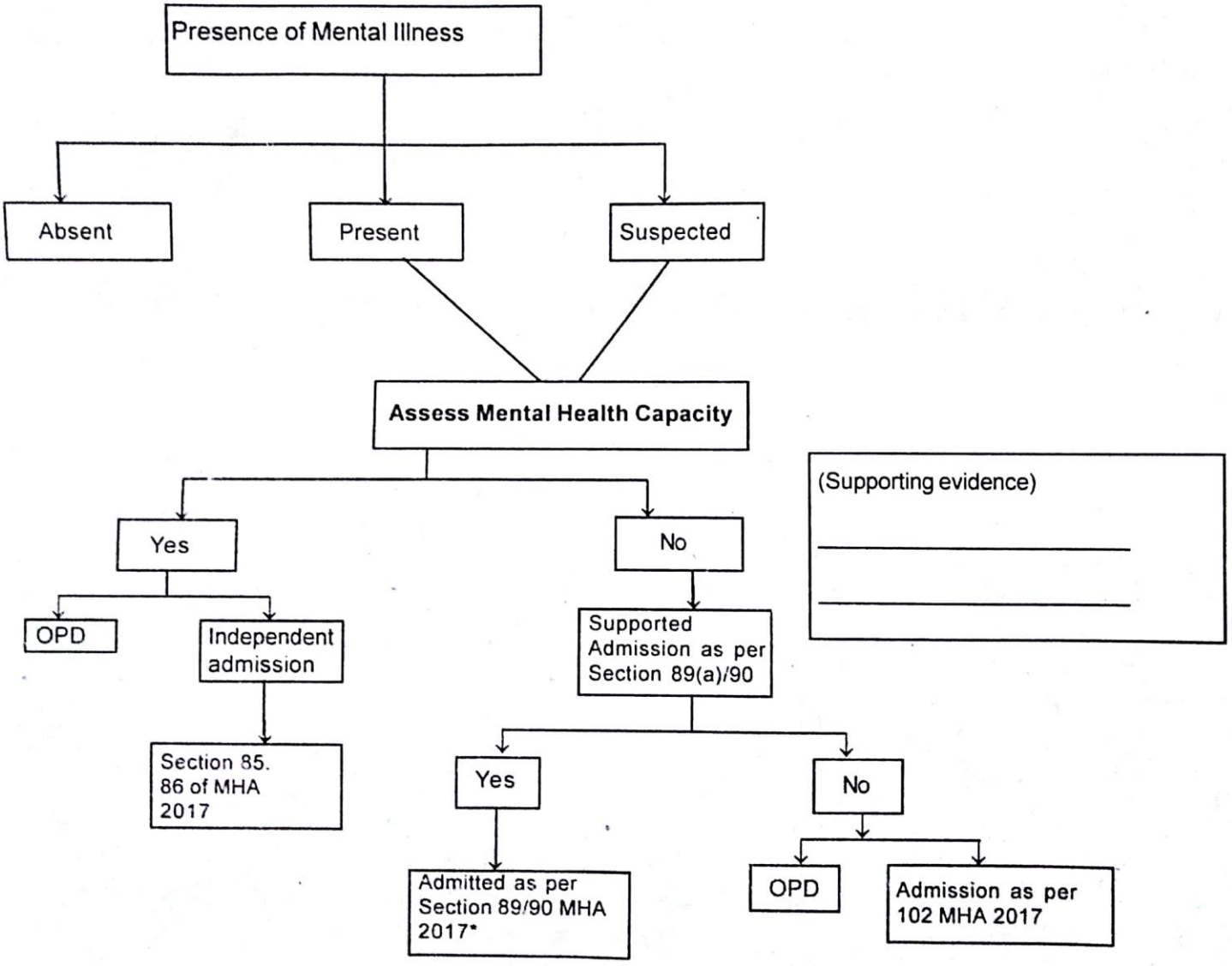
ALGORITHM FOR HOSPITALIZATION / ADMISSION

Name …….Age ……..Sex……..

U.I.D. No……..

ALGORITHM FOR NEED FOR HOSPITALIZATION



- For all suspected psychiatric illness, admission should be preferably done as per Section 102 of MHA, 2017, more specifically in cases of conflict of interest.

Date : **Signature of Mental Health Professional**

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INDEPENDENT ASSESSMENT FOR ADMISSION AND TREATMENT

Name of Patient: **Age:** **Sex:** **Date:**

UID. No.

Nominated Representative: Yes / No **Advance Directive: Yes / No**

I, Dr._____have independently examined Mr. / Ms. _____on _____(Date) and on examination and the available history / information. He / She suffers from the following signs and symptoms.

1.

2.

3.

4.

5.

Hence, I independently conclude that the person has a mental illness of such severity that the person:

(Tick where appropriate)

(1) Has recently threatened or attempted or is threatening or attempting to cause bodily harm to himself, or

(2) Has recently behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him, or

(3) Has recently shown or is showing an inability to care for himself to a degree that places the individual at risk of harm to himself.

(Signature)
Name :
Mental Health Professional
Stamp with Designation

RECORD OF STEPWISE APPROACH FOR ASSESSMENT AND ADMISSION TO MHE AS PER MHA, 2017 FOR EVERY ADMISSION AND CHANGE OF SECTION FOR ADMISSION

Name of Patient: **Age:** **Sex:** **Date:**

UID. No.

Nominated Representative: Yes / No **Advance Directive: Yes / No**

Step 1:

A) The patient's Mental Health Capacity is assessed and is annexed.	B) **Consent for Independent Admission** (To extent possible): Based on the examination and available history / information as concurred and approved. I request you to sign your ***Independent Admission under section 85, 86 of MHA, 2017*** ***Signature of Patient:_____***

Step 2 (Supported Admission upto 30 days):

I, the undersigned have seen that the doctors have offered independent admission to my patient; however the patient has refused to sign above. Hence, I Mr. / Ms. / Mrs. _____,

Relationship with the patient,_____ nominated representative / family member / relative / caregiver / NGO, is of the opinion that my patient is in need of supported admission. Hence, I request the **Medical Officer In-Charge** of **Rama De-addiction and Rehabilitation Centre** to admit my patient under ***Section 89. (Admission of person with mental illness with High support needs in MHE, upto 30 days)***.

As the admission is supported, in case of any grievance, he can and will be assisted by the team to have access to legal aid services / DSLSA and / or approach MHRB.

Signature: _____

Name: _____

The patient, Mr. / Ms. / Mrs._____, his condition is such that he / she requires to be kept under observation or inpatient evaluation and treatment at **Rama De-addiction & Rehabilitation Centre** under Section 89 (Admission of person with mental illness with High support needs in MHE, upto 30 days) and he is not able to make request for his Mental Healthcare as his Mental Health Capacity is found to be absent.

Step 3 (Supported Admission upto 90 days):

I, the undersigned have seen that the doctors have offered independent admission to my patient; however the patient has refused to sign above. Hence, I Mr. / Ms. / Mrs. _____,

Relationship with the patient, _____ nominated representative / family member / relative / caregiver / NGO, is of the opinion that my patient Mr. /Ms. / Mrs._____ who is currently admitted at **Rama De-addiction & Rehabilitation Centre** since_____ is in need of supported admission beyond 30 days. Hence, I request the **Medical Officer In-Charge** of **Rama De-addiction and Rehabilitation Centre** to admit my patient under ***Section 90 (Admission of person with mental illness with High support needs in MHE, beyond 30 days) of Mental Healthcare Act, 2017.***

Signature: _____

Name: _____

The patient, Mr. / Ms. / Mrs._____, is currently admitted at **Rama De-addiction & Rehabilitation Centre** since _____. His condition is such that he / she **requires to be treated as an inpatient as per Section 90**(Admission of person with mental illness with High support needs in MHE, beyond 30 days) of Mental Healthcare Act, 2017 and he is not able to make request for his Mental Healthcare as his Mental Health Capacity is found to be absent.

I have satisfied myself that the patient's illness is of such severity that the person;***(Tick where appropriate)***

(1) Has recently threatened or attempted or is threatening or attempting to cause bodily harm to himself, or

(2) Has recently behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him, or

(3) Has recently shown or is showing an inability to care for himself to a degree that places the individual at risk of harm to himself.

Hence, he / she requires to be in the MHE for his treatment / safety of self or others.

Concurrence & Approval if required	
Visiting Psychiatric / Consultant (Signature with Stamp)	Medical Officer In-Charge of Rama De-addiction & Rehabilitation Centre) Signature with Stamp

PERIODIC REVIEW OF CONSENT

The patient is admitted under Section 89 / 90 of Mental Healthcare Act, 2017, since _____ (Date) and he has been periodically examined as per Section 89 (8) / Section 90 (13) on the following dates and the decision taken thereof is given below :

Date	**Current Section**	**Mental Health Capacity**	**Decision regarding change of Section**	**Change of the Ward Setting with rationale if setting has not been changed**	**Signatures of Mental Health Professionals**

APPLICATION FOR INDEPENDENT ADMISSION

To,

The Medical Officer In-Charge,

Rama De-addiction & Rehabilitation Centre

41-B, Asola, Fatehpur Beri, Delhi-110074

Subject: Request for Independent Admission in your Mental Health Establishment.

Sir / Madam,

I, Mr. / Ms. / Mrs. _____

Age _____ son / daughter of_____

Residing at _____

_____

I have mental illness with following symptoms since _____

1.
2.
3.

The Following papers related to my illness as available with me are enclosed.

1.
2.
3.

I wish to be admitted in your establishment for treatment and request you to please admit me **as an independent patient**. A self – attested copy of my ID Proof is enclosed.

Address: Signature

Date:Name:

APPLICATION FOR ADMISSION OF A MINOR

To,

The Medical Officer In-Charge,

Rama De-addiction & Rehabilitation Centre

41-B, Asola, Fatehpur Beri, Delhi-110074

Subject: Request for Admission of a Minor in your Mental Health Establishment.

Sir / Madam,

I, Mr. / Mrs. _____

Residing at _____

_____who is the nominated representative (being legal guardian) of

_____son / daughter of _____

For treatment of mental illness.

He / she is having the following symptoms since _____

1.

2.

3.

The Following papers related to his / her illness as available with me are enclosed.

1.

2.

3.

Kindly admit him/her in your establishment for **as minor patient**. A self – attested copy of my ID Proof is enclosed.

Address: Signature

Date: Name:

APPLICATION FOR ADMISSION WITH HIGH SUPPORT NEEDS

To,

The Medical Officer In-Charge,

Rama De-addiction & Rehabilitation Centre

41-B, Asola, Fatehpur Beri, Delhi-110074

Sir / Madam,

I, Mr. / Mrs. _____

Residing at _____

_____who is the nominated representative (being legal guardian) of

Mr. / Mrs. _____ aged_____son / daughter of _____

_____request for his/her admission in your establishment for treatment of mental illness.

He / she is having the following symptoms since _____

1.

2.

3.

The Following papers regarding my appointment as nominated representative and related to his / her illness as available with me are enclosed.

1.

2.

3.

Kindly admit him/her in your establishment for **as patient with high support needs**. A self – attested copy of my ID Proof is enclosed.

Address: Signature

Date: Name:

APPLICATION FOR *CONTINUOUS* ADMISSION WITH HIGH SUPPORT NEEDS

To,

The Medical Officer In-Charge,

Rama De-addiction & Rehabilitation Centre

41-B, Asola, FatehpurBeri, Delhi-110074

Sir / Madam,

I, Mr. / Mrs. _____

Residing at _____

_____who is the nominated representative (being legal guardian) of

Mr. / Mrs. _____ aged_____son / daughter of _____

_____, who is / was an inpatient in your establishment under supported admission category, request for his/her continued admission beyond thirty days / readmission within seven days of discharge for the reasons stated below.

1.

2.

Kindly continue his / her admission / readmit him/her in your establishment for **as patient with high support needs beyond 30 days.** A self – attested copy of my ID Proof is enclosed.

Address: Signature

Date: Name:

APPLICATION FOR DISCHARGE BY INDEPENDENT PATIENT

To,

The Medical Officer In-Charge,

Rama De-addiction & Rehabilitation Centre

41-B, Asola, Fatehpur Beri, Delhi-110074

Subject: Request for Discharge

Sir / Madam,

I, Mr. / Mrs. _____

Residing at _____

_____ aged_____son / daughter of _____

_____, was admitted in your MHE as an Independent Admission patient on _____, I now, feel better and wish to be discharged. Kindly arrange to discharge me immediately.

Address: Signature

Date: Name:

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GENERAL CONSENT FORM

(To be signed by Patient / Relative, in all cases)

The scope of the general consent covers all routine and necessary medical assessment and investigations, like blood, urine, radiological examinations, IV Line, psychological and psychosocial assessments like detailed individual and family interview, counseling and intervention by a team.

The scope does not cover special / invasive or surgical and anesthetic procedures like Lumber Puncture. Biospy-Muscle/nerve, ECT etc. for which separate consent would be obtained.

In an emergency, the scope would cover all necessary procedures or lifesaving interventions.

Signature …..…….

Place ……..

Name …….

Relationship ……..

Date ……

Full Address……..

I /We have been advised to not leave any valuables with the patient during admission, and I/We shall solely responsible for the safety of these valuables and belongings if any.

(Signature of the Patient / Relative)

Date and Time:

(***Countersigned*** by the Nursing Staff/ Staff)

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DECLARATION REGARDING DISCHARGE OF PATIENT

(To be signed by Relative of patient / client, in all cases)

I, Shri /Smt. …….....(Relationship)……..……

of the patient ……., hereby agree to abide by the decision of the Medical Officer In-Charge of Rama De-addiction & Rehabilitation center, in regard to the discharge of the patient and shall whenever directed immediately arrange to take the patient at home; otherwise the patient may be discharged as per rules of the center / facility.

Signature …..…….

Place ……..

Name …….

Relationship ……..

Date ……

Full Address……..

RAMA DE-ADDICTION & REHABILITATION CENTRE

Treatment Card for Patient Case File

Patient Name : Age : Sex :

UID No. : Consultant I/C : Weight :

Ward / Section : Date of Admission : Unit :

DIET : Drug Hypersensitivity / Allergies :

DIAGNOSIS

Date & Time of Instructions (Start / Revised)	IV Fluids / Injectable/ Drugs (Generic Name in block letters)	Route	Dose	Frequency	Name of Medical Officer	Instructions recd. by Staff / Nurse	**DATE OF STOP** **M.O.**	**Nurse**

RAMA DE-ADDICTION & REHABILITATION CENTRE

Treatment Card for Patient Case File

Patient Name :	Age :	Sex :
UID No. :	Consultant I/C :	Weight :
Ward / Section :	Date of Admission :	Unit :
DIET :	Drug Hypersensitivity / Allergies :	

EMERGENCY / SOS DIAGNOSIS

Date & Time of Instructions (Start / Revised)	**Emergency / SOS Medications administered**	Route	Dose	Frequency	Name of Medical Officer	Instructions recd. by Staff / Nurse	**DATE OF STOP** **M.O.**	**Nurse**

PSYCHOSOCIAL INTERVENTION
