

The Mental Health (Care and Treatment) (Scotland) Act 2003 (the Act)

Certificate of the Designated Medical Practitioner

For example

T3A (S237)

Not like this ->

Shade circles like this ->

Instructions v 7.0

The following form is to be used:

Write clearly within the boxes in

BLOCK CAPITALS and in BLACK or BLUE ink

where a designated medical practitioner is required to provide a certificate for medical treatment where a patient is incapable of consenting to treatment under section 237(3) of the Act:

- (a) electro-convulsive therapy (ECT);
- (b) vagus nerve stimulation (VNS); and
- (c) transcranial magnetic stimulation (TMS).

Note: ECT, VNS and TMS cannot be given where the patient is capable of consenting to the treatment and refuses consent.

This form is prescribed by regulations made under the Mental Health (Care and Treatment) (Scotland) Act 2003. The use of any other form for the purpose for which this form have been prescribed is invalid.

Where not completing this form electronically, to ensure accuracy of information, please observe the following conventions:

| Patient Details | | | | | | | | | | | | | | | | | | | | | | | | | |
|--------------------------------|----------|--------|-------|--------|--------|-------|-------|------|--------|--------|-------|--------|-------|------|-------|------|------------|-------|-----|---|---|-------------|---|---|---|
| CHI Number | | | | | | | | | | | | | | | | | | | | | | | | | |
| Surname | | | | | | | | | | | | | | | | | | | | | | | | | |
| First Name(s) | | | | | | | | | | | | | | | | | | | | | | Т | Т | | |
| Other / Known As | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 'Oth | er / K | nown | As' co | ould i | nclud | e any | nam | ne / a | ias th | at th | e pati | ent w | ould | prefe | to b | e kno | wn as | 3. | | | | | 1 | |
| Γitle | | | | | | | | | | | | | | Ger | nder | | ○ N | /lale | | | | | | | |
| OoB dd/mm/yyyy | | | / | | | / | | | | | | | | | | | ○ F | em | ale | | | | | | |
| Patient's home address | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Postcode | | | | | | | | | | ı | ı | ı | | | | | 1 | 1 | | ı | I | | | | |
| The patient is detained | d in, or | unc | ler t | he n | nan | age | mei | nt / | car | e of | : | | | | | | | | | | | | | | |
| Hospital | | | | | | | | | | | | | | | | | | | | | | | | | |
| Ward / Clinic f appropriate | | | | | | | | | | | | | | | | | | | | | | | | | |
| Patient's RMO | | | | | | | | | | | | _ | | | _ | | | | | | | | | | _ |
| aucill 5 MiVIO | | | | | | | | | | | | | | | | | | | | | | | | | |



○ The RMO is a child specialist ○ The RMO is NOT a child specialist

(see notes - page 2)

| Patient's Name | | CHI Number | | | | | | | | | |
|---|---|---|--|--|--|--|--|--|--|--|--|
| | | To be completed by the DN | | | | | | | | | |
| DMP Details | | | | | | | | | | | |
| Surname | | | | | | | | | | | |
| First Name | | | | | | | | | | | |
| Address | | | | | | | | | | | |
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| | | | | | | | | | | | |
| Postcode | GMC Number | r | | | | | | | | | |
| Where the netions is under the | va of 40 | | | | | | | | | | |
| Where the patient is under the ag ○ I, the above DMP am a ch | | am NOT a child specialist (see notes below) | | | | | | | | | |
| , | | | | | | | | | | | |
| CERTIFICATION | | | | | | | | | | | |
| The treatment covered by t | this certificate is: | | | | | | | | | | |
| ○ ECT under section | 5 FOT a large of the 207/01/c) | | | | | | | | | | |
| O VNS or TMS (being | g treatments specified in regulations und | der section 237(3)(b)) | | | | | | | | | |
| I, the above named DMP, r | not being the patient's RMO certify that: | | | | | | | | | | |
| | e of understanding the nature, purpose a | and likely effects of the treatment; and | | | | | | | | | |
| the giving of medical t Act 1995, and | reatment to the patient is authorised by v | virtue of the Act, or the Criminal Procedure (Scotlar | | | | | | | | | |
| Complete A or B as appropriate | for treatments under section 237(3) | | | | | | | | | | |
| | | aving regard to the likelihood of its alleviating, or | | | | | | | | | |
| | | he patient's best interests that the treatment should | | | | | | | | | |
| OR | | | | | | | | | | | |
| B O the patient resists or | objects to treatment, and it is necessary | ry to give treatment to the patient for the purpose of: | | | | | | | | | |
| (a) saving the patie | ent's life; | | | | | | | | | | |
| O (b) preventing seri | ous deterioration in the patient's conditio | on; | | | | | | | | | |
| ○ (c) alleviating serio | ous suffering on the part of the patient. | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| Notes | | | | | | | | | | | |

Where the patient is under the age of 18, certification MUST be as follows -

where the patient's RMO is a child specialist, by a designated medical practitioner approved by the Mental Welfare Commission where the patient's RMO is not a child specialist, by a designated medical practitioner approved by the Commission who is a child specialist

Where the patient is not in hospital the above certificate does not authorise the giving of treatment by force to the patient



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| | Patient's Name | | CHI Number | | | | | | | |
|--|--|--|------------|--------------------|-----------|--|--|--|--|--|
| | | | | To be completed by | y the DMP | | | | | |
| Details of Treatment | | | | | | | | | | |
| Description of the treatment(s) including frequency. The maximum duration of the course of treatment authorised must be stated | | | | | | | | | | |
| 1 | | | | | | | | | | |
| Sign | nature | | | | | | | | | |
| | | | | | | | | | | |
| Signo by the | e DMP | | | | | | | | | |
| Date dd / mr | m / yyyy | | | | | | | | | |
| A cop | A copy of this form must be sent to the Mental Welfare Commission within seven days of issuing the certificate | | | | | | | | | |

| | | | Patient's Name | | | CHI Number | | | | | | | |
|------|-----------------------------------|--|--|---|-----------------|--------------------|-------------------------------|-------------|--|--|--|--|--|
| A | dva | nce S | Statement (not p | part of the prescribed for | rm) | | To be completed b | y the DMP | | | | | |
| Con | Complete A, B or C as appropriate | | | | | | | | | | | | |
| Α | \circ | As far | as is practicable | to ascertain, the patient does | s not have an a | idvance statemer | nt under S275 of the Act. | ; ! ! | | | | | |
| Ol | R | | | | | | | | | | | | |
| В | 0 | and a | | to ascertain: the patient has thorise or not authorise treatn | | | | | | | | | |
| Ol | R | | | | | | | | | | | | |
| С | 0 | stater | Decision(s) I have made to authorise or not authorise treatment ARE in conflict with wishes specified in an advance statement made by the patient under S275 of the Act and not withdrawn. Please record in the box below: | | | | | | | | | | |
| | | The date of the advance statement(s). Details of all treatment(s) authorised that are in conflict with the advance statement and how. Where a decision that conflicts with the advance statement is a decision not to authorise treatment, please provide details of this. Your reasons for authorising/not authorising these treatment(s), despite the conflict with the advance statement, with reference to your consideration of the Principles of the Act. | | | | | | | | | | | |
| | | When | e the treatment is | s in conflict with the advance s | statement a re | ecord of the above | e has been sent to: | | | | | | |
| | | | patient | | | s welfare attorney | | | | | | | |
| | | | patient's named | | the patient's | • | | | | | | | |
| | | | • | Commission (a copy of this fo | • | - | nas been sent to the patient/ | others) | | | | | |
| C | ons | ultati | on (not part of | the prescribed form) | | | To be completed b | ov the DMP | | | | | |
| | | | | rtificate I have consulted w | vith - | | • | | | | | | |
| | | | ient; and | | | | | | | | | | |
| • | • | - | | rson (if they have one); and | d | | | | | | | | |
| O (d | c) a | ny gua | ardian of the pat | ient; and | | | | | | | | | |
| O (c | d) a | ny we | Ifare attorney of | the patient; and | | | | | | | | | |
| ○ (€ | e) s | uch pe | erson or persons | s as appear to be principal | ly concerned | with the patient | s medical treatment (listed | d below) | | | | | |
| 3 | | | | | | | | | | | | | |
| lt w | as i | mpra | cticable to consu | ult any person mentioned ir | n (a), (b), (c) | and (d) above fo | or the following reasons: | | | | | | |
| 4 | | | | | | | | | | | | | |

