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

Certificate Of Consent To Treatment - Artificial Nutrition

T2C

Instructions v7.1

The following form is to be used:

Where by or under the direction of the patient's RMO, the patient is given the following treatment that they are capable of consenting to and not refusing consent for: provision of nutrition by artificial means.

For patients aged 18 or older, this form should be completed by the patient's RMO.

For patients under the age of 18, the RMO should complete the form if they are a child specialist. If the RMO is not a child specialist, an approved medical practitioner (AMP) who is a child specialist should complete the form.

There is no statutory requirement that you use this form but you are strongly recommended to do so. This form draws attention to some good practice and procedural requirements under the Mental Health (Care and Treatment) (Scotland) Act 2003.

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

Write clearly within the boxes in BLOCK CAPITALS and in BLACK or BLUE ink

For example

2	5		M	A	R	K	E	T		S	T

Shade circles like this -> ●

Not like this -> ⊗ ✓

Where a text box has a reference number to the left, you can extend your response on plain paper where there is insufficient space in the box. Extension sheet(s) should be clearly labelled with Patient's name and CHI number, and each extended response should be labelled with the appropriate text box reference number.

Patient Details

CHI Number

Surname

First Name(s)

Other / Known As

'Other / Known As' could include any name / alias that the patient would prefer to be known as.

Title

DoB
dd / mm / yyyy

Gender

○ Male ○ Female ○ Prefers not to say ○ Not listed

If not listed, please specify

Patient's home address

Postcode

<< Please enter NF1 1AB if no fixed abode

The patient is detained in, or under the management / care of:

Hospital

Ward / Clinic

Patient's Name | CHI Number

RMO Details

Surname

First Name

Title | GMC Number

Hospital

Ward / Clinic
(If appropriate)

Telephone No.

e-mail address

Approved under section 22 of the Act by:

Health Board **NHS**

To be completed where the patient is under the age of 18

○ I am the patient's RMO and I am a child specialist; or

○ I am not the patient's RMO. I confirm that I am a child specialist

Details of approved medical practitioner completing this form if not the RMO

Surname

First Name

Title | GMC Number

Hospital

Ward / Clinic
(If appropriate)

Telephone No.

e-mail address

Approved under section 22 of the Act by:

Health Board **NHS**

Certification

Patient's consent to treatment

I, the above named RMO or AMP confirm that:

○ (a) the patient is capable of consenting to the treatment;
and

○ (b) the patient has consented in writing to the treatment (see note below)

Details of the patient's consent in writing to the treatment

○ A copy of the patient's consent in writing is attached.

The patient signed this consent on (date) / /

NB you should not complete this form before the patient signs the consent form as you are declaring on this form that the patient's written consent exists.

The Commission advises that you should complete this form as soon as possible after the patient signs the consent form, and no later than 7 days after they do so.

Note

If consent to treatment has been withdrawn (in writing or otherwise) then the treatment can not be given

Patient's Name | CHI Number

Details Of Treatment

Description of the treatment including route of administration, treatment goal and duration of treatment

1	

Treatment can be authorised by this certificate until (date) ☐☐ / ☐☐ / ☐☐☐☐

Note: duration of treatment should also be recorded in the description of treatment as above.

Certification by RMO or AMP

Signature

Date ☐☐ / ☐☐ / ☐☐☐☐

Please send a copy of this form to the Mental Welfare Commission within seven days of completing it.