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

# Safeguards for treatment by certain surgical operations

**T1**

## *Instructions*

**v7.0**

**The following form is to be used:**

where a certificate of consent is required for the following types of medical treatment:
(a) any surgical operation for destroying-
(i) brain tissue or
(ii) the functioning of brain tissue; and
(b) the treatment known as deep brain stimulation.

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 has been prescribed is invalid.

*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

*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

Gender ○ Male ○ Female

DoB
dd / mm / yyyy
/ /

Patient's home address

Postcode

The patient will be treated in:

Hospital

Ward / Clinic

Patient's Name | CHI Number

***Patient's RMO (see note 1 below)***

Surname

First Name

Title GMC Number

Hospital

Ward / Clinic
(If appropriate)

I, the above named RMO am approved under section 22 of the Act by:

Health Board **NHS**

***Where the patient is under the age of 18 -***

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

**T1 / PART 1** **To be completed by the DMP**

***DMP Details (see note 2 below)***

***Full name and professional address of DMP who is providing the certificate***

Surname

First Name

GMC Number

Address

Postcode

***Where the patient is under the age of 18 -***

○ I am a child specialist ○ I am NOT a child specialist

***Certification***

***Complete the appropriate option***

***A - complete where - Patient is Capable of Consent to Treatment***

I, the above named DMP, confirm that:

○ (a) the above named patient is capable of consenting to the treatment

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

○ (c) having regard to the likelihood of its alleviating, or preventing a deterioration in, the patient's condition, it is in the patient's best interests that the treatment should be given to the patient

***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) / /

***B - complete where - Patient is Incapable of Consent to Treatment***

I, the above named DMP confirm that:

○ (a) the above named patient is incapable of consenting to the treatment

○ (b) the patient is not objecting to the treatment; and

○ (c) having regard to the likelihood of its alleviating, or preventing a deterioration in, the patient's condition, it is in the patient's best interests that the treatment should be given to the patient

**Notes**

1. Where the patient does not have an RMO, all references in this form to the patient's RMO will be taken to be the medical practitioner primarily concerned with treating the patient.
2. Where the patient is a child (under the age of 18) and the patient's RMO is NOT a child specialist, then the DMP must be a child specialist (where a child specialist is a medical practitioner who has such qualifications or experience in relation to children as the Mental Welfare Commission may determine from time to time)

Patient's Name | | CHI Number | |

**T1 / PART 2** — **To be completed by the DMP**

### *Treatment Details*

The treatment under section 234(2) is to consist of ***(shade as appropriate) :***

○ (a) any surgical operation for destroying-
(i) brain tissue; or
(ii) the functioning of brain tissue

○ (b) the treatment known as deep brain stimulation.

***Description of the treatment.***

| 1 | |
|---|---|

### *Signature / Date*

Signed
by the DMP

Date __ __ / __ __ / __ __ __ __

***The DMP should complete Parts 3 & 4 (page 4) and then ensure that Part 5 (page 5) is completed and counter-signed by each of the Mental Welfare Commission appointees.***

***A copy of the whole of form T1 must then be sent to the Mental Welfare Commission within seven days of issuing the certificate***

Patient's Name | | CHI Number | |

**T1 / PART 3 (not part of the prescribed form)** **To be completed by the DMP**

***Advance Statement***

***Complete A, B or C as appropriate***

**A** ○ As far as is practicable to ascertain the patient does not have an advance statement under S275 of the Act

**OR**

**B** ○ As far as is practicable to ascertain: the patient has made and not withdrawn an advance statement under S275 of the Act; and no treatment authorised in this certificate is in conflict with that advance statement.

**OR**

**C** ○ Treatment authorised in this certificate IS 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.
- Details of how treatment(s) authorised are in conflict with the advance statement.
- Where the 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 this treatment, despite the conflict with the advance statement, with reference to your consideration of the Principles of the Act.

| **2** | |
|---|---|

Where the treatment is in conflict with the advance statement, a record of the above has been sent to:

○ the patient
○ the patient's welfare attorney
○ the patient's named person (if any)
○ the patient's guardian
○ the Mental Welfare Commission (a copy of this form and any other record which has been sent to the patient/ others)

**PART 4 (not part of the prescribed form)** **To be completed by the DMP**

***Consultation***

Prior to the issuing of this certificate I have consulted with -

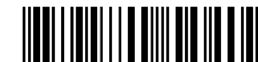
○ (a) the patient
○ (b) the patient's named person
○ (c) any guardian of the patient
○ (d) any welfare attorney of the patient
○ (e) such person or persons as appear to be principally concerned with the patient's medical treatment (listed below)

| **3** | |
|---|---|

It was impracticable to consult any person mentioned in (a), (b), (c) and (d) above for the following reasons:

| **4** | |
|---|---|

***Note: The person giving a certificate need not consult any person such as is mentioned in (a) - (d) above in any case where it is impracticable to do so.***



Patient's Name | | CHI Number | 

**T1 / PART 5 : MENTAL WELFARE COMMISSION APPOINTEES (not part of the prescribed form)**

***Part 5a : to be completed by the first person appointed by the Mental Welfare Commission***

Surname

First Name

Address

Postcode

I, the above named person appointed by the Mental Welfare Commission certify that -

○ In regard to the requirements of section 235 of the Act, the patient is capable of consenting to the treatment and the patient consents in writing to the treatment, or

○ In regard to the requirements of section 236 of the Act, the patient is incapable of consenting to the treatment and the patient does not object to the treatment.

***Consultation***

Prior to the issuing of this certificate I have consulted with -

○ (a) the patient

○ (b) the patient's named person

○ (c) any guardian of the patient

○ (d) any welfare attorney of the patient

○ (e) such person or persons as appear to be principally concerned with the patient's medical treatment (listed below)

**5**

It was impracticable to consult any person mentioned in (a), (b), (c) and (d) above for the following reasons:

**6**

***Note: The person giving a certificate need not consult any person such as is mentioned in (a) - (d) above in any case where it is impracticable to do so.***

Signature

Date __ / __ / ____

Patient's Name [ ] CHI Number [ ]

**T1 / PART 5 (cont) : MENTAL WELFARE COMMISSION APPOINTEES (not part of the prescribed form)**

***Part 5b : to be completed by the second person appointed by the Mental Welfare Commission***

Surname

First Name

Address

Postcode

I, the above named person appointed by the Mental Welfare Commission certify that -

○ In regard to the requirements of section 235 of the Act, the patient is capable of consenting to the treatment and the patient consents in writing to the treatment.

○ In regard to the requirements of section 236 of the Act, the patient is incapable of consenting to the treatment and the patient does not object to the treatment.

***Consultation***

Prior to the issuing of this certificate I have consulted with -

○ (a) the patient

○ (b) the patient's named person

○ (c) any guardian of the patient

○ (d) any welfare attorney of the patient

○ (e) such person or persons as appear to be principally concerned with the patient's medical treatment (listed below)

**7**

It was impracticable to consult any person mentioned in (a), (b), (c) and (d) above for the following reasons:

**8**

***Note: The person giving a certificate need not consult any person such as is mentioned in (a) - (d) above in any case where it is impracticable to do so.***

Signature

Date / /