

Mental Health Act 1986

Sections 19A & 73

Local Hospital Patient Number:

Grid for Local Hospital Patient Number

Family Name:

Given Names:

Date of Birth: Sex:

Alias:

Mental Health Statewide Patient Number

Grid for Mental Health Statewide Patient Number

AUTHORITY TO PERFORM ELECTROCONVULSIVE THERAPY WHERE INFORMED CONSENT NOT OBTAINED

Notes to completing this form

The decision to prescribe ECT must be consistent with the treatment objectives and strategies contained in the patient's treatment plan.

In reviewing the treatment plan to include ECT, you must take into account the wishes of:

- the patient, as far as they can be ascertained.
any guardian, family member or primary carer who is involved in providing ongoing care or support to the patient (unless the patient objects).

All reasonable efforts must be made to notify the patient's guardian or primary carer of the proposed performance of ECT.

If more than 7 days elapses between any two treatments in a course, the course is deemed to be finished. Further treatment will need a new authority.

Form for patient details: GIVEN NAME/S, FAMILY NAME (BLOCK LETTERS) of patient, checkboxes for involuntary patient, security patient, forensic patient, and a patient of: approved mental health service.

(1) The abovenamed patient has the following mental illness for which I consider electroconvulsive therapy (ECT) is an appropriate treatment:

principal diagnosis to be treated by ECT

(2) I am satisfied that:

- The patient is incapable of giving informed consent to ECT.
ECT has clinical merit and is appropriate treatment for the patient's mental illness.
Having regard to any benefits, discomforts or risks, the ECT should be performed.
Any beneficial alternative treatments have been considered.
Unless the ECT is performed, the patient is likely to suffer a significant deterioration in his or her physical or mental condition.

(3) I therefore authorise ECT to be performed on the patient.

(4) The reasons for my decision are:

(5) This authority is valid for:

a single treatment to be performed on the day of 20

OR

a course of (not more than 6) treatments.

(please cross X)

The course of treatments is to commence on the day of 20

The course of treatments is to be completed on the day of 20

(6) The patient's \*guardian/primary carer: name of guardian/primary carer

was notified about the proposed ECT on:

If the guardian/primary carer was not notified give reasons:

I am the \* delegated / authorised psychiatrist of the approved mental health service.

The patient has been given a copy of the patients' rights booklet Electroconvulsive Therapy and the information explained.

The patient's treatment plan has been reviewed, revised and discussed with the patient.

(please cross X)

GIVEN NAME/S FAMILY NAME (BLOCK LETTERS) of \* delegated/ authorised psychiatrist

Signed: Date:

\* delete as necessary

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MHA 25 AUTHORITY FOR ECT - CONSENT NOT OBTAINED