EMERGENCY ELECTROCONVULSIVE THERAPY WITHOUT CONSENT

(MRMHA-M)

1a. Affix patient identification label in this box

Hospital: .....

UR No: .....

Surname: .....

Given Name: .....

Second Given Name: .....

D.O.B: ..... Sex: .....

Mental Health Act 2009—Section 42 (6) and (7)

1b. PERSON ADDRESS DETAILS *(if not on or different from patient label above)*

Address: .....

Suburb/town: ..... Postcode: ___ ___ ___ ___

2. EXAMINATION OF PERSON

I have examined the above named person on:

__ __ /__ __ / 20 __ __ at __ __ : __ __ (24-hour clock)

Location of examination: .....

Please specify: emergency dept, ward and hospital, community mental health site, GP clinic or residence.

I consider that the person has a mental illness of such a nature that the administration of an episode of ECT is urgently needed for the person's wellbeing, that the person does not have decision making capacity and that it is not practicable to obtain consent from a substitute decision maker or SACAT in the current circumstances.

3. PSYCHIATRIST AUTHORISING EMERGENCY ECT

Full Name *(Please print)*:	Psychiatrist
Signature:	__ __ /__ __ / 20 __ __ at __ __ : __ __ (24-hour clock)
Work address *(Please print)*:	

4. HEALTH SERVICE / AGENCY OBLIGATIONS

The person must be given a copy of this form as soon as practicable.
The guardian, substitute decision maker (medical agent), relative, carer or friend must be given a copy of this form (if appropriate) as soon as practicable.
The Chief Psychiatrist must be sent a copy of this form within 1 business day.
The reasons for the making of this authorisation, the provision of copies and making of notifications must be noted in the person's medical records and/or casenotes, whether electronic or paper-based.

EMERGENCY ECT WITHOUT CONSENT

MRMHA-M