SCOTTISH STATUTORY INSTRUMENTS

2017 No. 176

MENTAL HEALTH

The Mental Health (Certificates for Medical Treatment) (Scotland) Regulations 2017

Made - - - - 30th May 2017
Laid before the Scottish
Parliament - - - 1st June 2017
Coming into force - - 30th June 2017

The Scottish Ministers make the following Regulations in exercise of the powers conferred by sections 245(2), 246(1) and 325 of the Mental Health (Care and Treatment) (Scotland) Act 2003(1) and all other powers enabling them to do so.

Citation, commencement and interpretation

- 1.—(1) These Regulations may be cited as the Mental Health (Certificates for Medical Treatment) (Scotland) Regulations 2017 and come into force on 30th June 2017.
 - (2) In these Regulations—
 - (a) "Form" means a Form set out in schedule 2; and
 - (b) any reference to a Form having a letter and a number is a reference to the Form having that letter and number in schedule 2.

Form of certificate

- **2.** Any certificate given under a section of the Mental Health (Care and Treatment) (Scotland) Act 2003 which is specified in an entry in column 1 of schedule 1 is to—
 - (a) contain the particulars set out in the Form which is specified in the corresponding entry in column 2 of that schedule; and
 - (b) be in the Form which is specified in column 2 of that schedule and set out in schedule 2.

Revocations

3. The Mental Health (Certificates for Medical Treatment) (Scotland) Regulations 2005(2) and the Mental Health (Certificates for Medical Treatment) (Scotland) Amendment Regulations 2008(3) are revoked.

St Andrew's House, Edinburgh 30th May 2017

MAUREEN WATT Authorised to sign by the Scottish Ministers

⁽²⁾ S.S.I. 2005/443. (3) S.S.I. 2008/316.

SCHEDULE 1

Regulation 2

Column 1	Column 2
Section 235	Form T1
Section 236	Form T1
Section 238, where the treatment is that mentioned in section 237(3)	Form T2A
Section 238, where the treatment is that mentioned in section 240(3)	Form T2B
Section 239	Form T3A
Section 241	Form T3B

SCHEDULE 2

Regulation 2(b)

Form T1

Instructions																									v7
The following form is to be u	used:																								
where a certificate of consent (a) any surgical operatio (i) brain tissue o (ii) the functionir (b) the treatment known a	n for our or ng of l	destr brain	oyin tiss	g- ue;	and		typ	es	of m	edic	al tre	eatn	nent												
This form is pr The	escrib use o																			Act 2	2003				
Where not completing this for	n elec	tron	ically	y, fo	ens	ure a	юси	rac	y of	info	mat	ion,	plea	ise (bse	rve	the	falla	wing	00	nver	tions	s:		
Write clearly within the boxes in		For	exa	mpl	е										St	ade	cin	cles	like	this	>	•			
BLOCK CAPITALS and in BLACK or BLUE ink	[2	5	N	1 A	R	K	Е	Т	5	S T							Not	like	this	.>	×		8	
Where a text box has a reference the box. Extension sheet(s) she tabelled with the appropriate to Patient Details	ould I	be c	leari	y lab	elle	d with																			
	_	_	_				_		_																
CHI Number																									
Surname	Т	Г																							
First Name(s)	\top						\neg																	П	
list ridific(s)						\rightarrow	\rightarrow	_			_		_				_	-	-	-	-	\rightarrow	_	-	
, ,	+						- 1					\neg													
Other / Known As	ther / K	nown	As' c	ould	inclus	de any	nam	e/a	lias th	at the	patie	ent w	ould	prefe	to be	e kno	wn a	5.						Ш	
Other / Known As	ther / K	nown	As' c	ould	nduc	se any	nam	e/a	lias th	at the	patie	1	-	prefe		_	wn a	-	7						
Other / Known As Fitle DoB	ther / K	nown	As' c	ould	ndue	de arry	nam	e/a	lias th	nat the	e patie	1	-		(O N	-								
Other / Known As Fitle DOB Warm (yyyy) Patient's home	ther / K	, nown	As' c	ouldi	ndue	de any	nam	e/a	lias th	ant the	s patie	1	-		(O N	fale								
Other / Known As Title DOB Advansivyyy Patient's home	ther / K		As' c	ould	nduc	de any	nam	e/a	lians th	ant the	e patie	1	-		(O N	fale								
Other / Known As Title DOB Advansivyyy Patient's home	ther / K	/ /	As' c	ould	/	de any	nam	e/a	lias th	ant the	s patie	1	-		(O N	fale								
Other / Known As Title DOB Advansivyyy Patient's home	ther / K	/ /	As'c	ould	/	de any	nam	e/a	lins th	nat the	s patie	1	-		(O N	fale								
Other / Known As Title DOB Advant/yyyy Patient's home	ther / K	/ /	As' c	ould	/	le any	nam	e/a	lins th	at the	s patie	1	-		(O N	fale								
Other / Known As Title DoB diamalysys Patient's home iddress	ther / K	/ /	As' c	ould i		de any	nam	e/a	lias th	sat the	s patie	1	-		(O N	fale								
Other / Known As Title DOB domn/yyyy Patient's home iddress Postcode			As' c	ouldi	/	de any	nam	e/a	lins th	nat the	s patie	1	-		(O N	fale								
Other / Known As		/ /	As' c	culdi		de any	nam	e/a	lins th	at the	s patie	1	-		(O N	fale								



	me												СН	ΙN	uml	ber										
Patient's RMO (see not	e 1 b	elc	w)																							
Surname					П		П			П		П									Τ	Τ	Τ	Т	Τ	Π
First Name	П	\neg	\neg	\neg	\exists	\exists	\neg			\exists		\forall	\top	\neg			\neg			Г	T	T	T	\top	†	1
Γitle													GN	ЛC	Nu	mbe	r				Τ	Γ	T		Τ	
-lospital	П	\neg		\neg	\exists	\exists	\exists			\exists										Г	T	T	Ť	†	T	
Ward / Clinic If appropriate)																										
, the above named RMO	am a	арр	rove	ed u	nde	rse	ectio	n 2	2 of	the	Act	by:									_					
Health Board NHS																										
Where the patient is under the The above named RMC	-			pec	ialis	ŧ	0	The	e ab	ove	nar	nec	l RM	10 i	s N	ОТ	a ch	nild	spe	cia	list					
T1 / PART 1																			То	be	cor	npl	ete	d b	y th	e DN
DMP Details (see note	2 be	lov	v)																							
Full name and profession	nal ac	ldre	ss	of Di	WP :	who	is p	rov	ridin	g th	e c	ertif	icate													
Surname											Г	Г				Τ	Т			\top						
First Name																T		Ţ								
GMC Number		Г	Г			Г	Г	Г																		
Address		Н	T			T	t	t	Τ	Т	Т	Τ	Τ	Т	Τ	Τ	Τ	T	Т	Т						
	\vdash	Н	\vdash			\vdash	+	+	+	+	+	+	+	+	+	+	+	+	+	+	\dashv					
	\vdash	Н	\vdash			\vdash	╁	╁	+	+	+	╁	+	╁	+	+	+	+	+	+	\dashv					
Postcode	\vdash	Н	\vdash	+		\vdash	+	+	_	-	_	_		_				-	_	_	_					
Where the patient is under th		of:	18 -	-		1		J																		
○ I am a child specialist	_			ОТ	a ch	nild:	spec	ciali	st																	
Certification																										
Complete the appropriate	opti	on																								
A - complete where - F	Patie	nt i	s C	apa	ble	of (Con	ser	nt to	Tre	eatr	ner	nt .													
I, the above named DMF	, cor	nfiri	n th	at:																						
○ (a) the above named p	atien	nt is	cap	able	e of	cor	sen	ting	g to t	he t	trea	tme	ent													
	sente	ed t	o th	e tre	atn	nen	t in v	vriti	ng;	and	l															
O (b) the patient has con			hod	of it	s al											n in	the	e pa	tier	nt's	con	diti	on,	it is		
 (b) the patient has con (c) having regard to th in the patient's best int 					reat	ime	I IL O			- 5																
(c) having regard to th	erest	ts th	nat t	he t					trea	_	ent															
 (c) having regard to the in the patient's best int 	eresi	ons	ent	in v	vrit	ing	to t	he		_	ent			_												
(c) having regard to the in the patient's best int Details of the patient	erest	ons sent	ent in	in v	writ	ing	to t	he		_	ent]										
O (c) having regard to the in the patient's best int Details of the patient's A copy of the patient's	erest	ons sent	ent in v	in v writinate)	writing in	ing s at	to t	the ned.		tme]/	tme	ent		L]										
(c) having regard to the in the patient's best int Details of the patient A copy of the patient's The patient signed this co	erest erest cons conser	ons sent nto	ent in (d	in v writinate)	writing in	ing s at	to t	the ned.		tme]/	tme	ent		L]										

- \bigcirc (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

- 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.
- 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 b	y the DMP
Trea	atment Details				ı
		234(2) is to consist of (shade as appro	priate) :		
	a) any surgical operation (i) brain tissue; or (ii) the functioning	g of braintissue			
		as deep brain stimulation.			
Desc 1	cription of the treatment.				
Ι.					
	1				
Sigi	nature / Date				
Sign	ed DMP				
Date		1 1			

Form T2A

Instructions																								_
The following form is to	o be us	ed:																						_
where the patient's RMC treatment under section (a) electro-convulsion (b) vagus nerve stin (c) transcranial mag	237(3) ve thera nulation	of th py (I VN	e Ac ECT) IS); a	t: ; ind,		e pat	Not	e: E(CT, V	ole of /NS ar stient ent a	nd 1 is c	rms apa	cann ble of	ot b	e gh	/en	an	d is	not r	efus	sing	cons	ent f	or
This form is prescribed	d by regu	ulatio	ns ma	ade und	ier th	e Me for w	ntal I	Heal this	th (C form	are ar	nd T	reat	ment) scribe	(Sc	otlar inva	id) Ar	ct 20	003.	The	use	of a	ny oth	er fo	m
Where not completing thi	is form e	elect	ronic	ally, to	ensi	ıre a	ccur	acv	of in	form	atio	n, pi	lease	obs	erv	e the	fol	lowii	na co	nive	entic	ons:		
Write clearly within the boxe.				examp				,				, ,				ade	oiro	lan	iko fi	him				
BLOCK CAPITALS and in BLACK or BLUE ink		Ĺ		T		\top	П	\neg			Т	٦					1	Not	like t	his -	>	×	O	/
abelled with the appropries Patient Details	riate tex	t bo	k refe	erence	num	ber.									_						_			
		_			_	_				,														
CHI Number																								
Surname					Τ	П								\neg								П		
First Name(s)																						П		
Other / Known As		Г		\top	\top	Г			Г	П				\exists		\exists						П	\top	┪
	'Oth	er/K	nown	As' could	d inclu	de any	nam	e / ali	ias th	at the p	atie	nt wo	uld pre	efer to	o be l	nown	as.							
Title									L				Geno	der	() Ma	ale							
DoB dd/mm/yyyy]/[]/) Fe	ma	ale						
Patient's home address					Τ																			
address		Г			Т	Г				П				\exists		\exists						П		\neg
		\vdash	\Box	\top	$^{+}$	T				П	\exists		\Box	\dashv		\forall						П	\top	┪
		\vdash	Н	\top	+	\vdash		\vdash	\vdash	\Box	\exists		\vdash	\dashv	\dashv	\dashv	\neg		\dashv			Н	\top	┪
	-	+	\vdash	+	+	+		-	-		+		\vdash	\dashv	-	+	-	-	\dashv	-	-	\vdash	+	-
Postcode	\vdash	\vdash		+	+	\vdash				Ш												Ш		
The patient is detained	d in, or	und	er th	e ma	nage	mer	nt/o	care	of:															
-lospital				\top										П	П							П	\top	
		=		=	+	$\dot{=}$	_	=	=		=	_	=	一	一	$\overline{}$	=		\equiv	_	_	一	\pm	⊣
Ward / Clinic				- 1				ı			- 1												- 1	



Patient's Nar	me												CI	HIN	lum	ber											
																То	be o	on	nple	ete	d b	у	the	DI	ИP	or F	RMO
RMO Details (where cer	tific	ate	gra	nte	d b	y ti	ne p	atio	ent's	s RI	MO)	ı															
Surname									Г	Г								Г	Т	Τ	Т			Т	Т	Τ	7
First Name				П		Т	Г		T	Г	Г						T	1	T	Ť	7			T	T		1
Title				П		Т	Г	Г	Т	Г	Г	_	G	MC	Nu	mb	er	_	T	Ť	+	_	_	T	Ť	Ť	
Hospital		П				Г		İ		Г			Ι.					Τ	+	t	+	_	_	╁	╁	+	+
Ward / Clinic (If appropriate)																				İ					İ	İ	
Felephone No.										Г						1											
e-mail address		ш		_			_	_		_	_	_	_	_	_	1											
																	Ι					Ι			Ι		
Approved under section 2	2 of	fthe	Ac	t by:																							
Health Board NHS								Г	Г				Г	Γ	Τ			Τ	Т	T			Γ	Τ	Т	Т	
Where the patient is under the	age	of 1	8 -			_	_	_	_				_	_	_				_				_	_			_
O I am a child specialist;	or	0	l an	n N	TC	a ch	nild :	spe	ciali	ist	(see	not	es)													
DMP Details (where cer	tific	ate	gra	nte	d b	y D	MP)	j.																			
Surname									Г			T	Г			Т	T	T	T	T							
First Name			_	_	_		\vdash	\vdash	\vdash	\vdash	\vdash	┢	╁	\vdash	+	╁	╁	╁	+	+	\dashv						
Address	_		_	_	_	-	H	\vdash	\vdash	\vdash	┝	╁	╁	\vdash	+	╁	╁	╁	+	+	\dashv						
	_		_	_	-		-	\vdash	⊢	⊢	\vdash	┝	╁	\vdash	+	╁	╀	╀	+	+	\dashv						
					H	H	H	\vdash	⊢	⊬	⊬	⊬	⊬	⊢	\vdash	⊬	╀	+	+	+	\dashv						
Postcode				H	L	H	H	\vdash						⊢	╀	╀	╀	╀	+	+	\dashv						
Posicode									GM	CIV	umi	ber		L			L	\perp									
Where the patient is under the OI, the above DMP am a	-			aliet			0.1	the	ab	0110	D14	D a	m N	OT	2.0	hild	ene	oio	liet		10.	00	nnt	es)			
	CHI	u sp	æui	ansı	, OI		Ο I,	LITE	au	ove	DIW	Pa	III IN	01	au	rillu	spe	Cla	list		(5)	ee	HOL	es)			
Certification																											
Patient's consent to tre																											
I, the above named RMO	or E	OMP	, co	nfirr	n th	at:																					
(a) the patient is capable of	of co	nser	nting	g to	the	trea	tmer	nt;																			
(b) the patient has cons	ente	ed in	ı wr	iting	to	the	trea	tme	ent (see	not	es)															
 (c) the giving of medica (Scotland) Act 2003, or 															ne N	1ent	alŀ	łea	lth (Ca	re	and	dΤ	rea	tme	ent)	
(d) having regard to the patient's best interests t															ation	n in,	the	pa	tien	t's	CO	ndi	tior	n, it	is i	n th	е
Details of the patient's	con	sen	nt in	wr	itin	g to	the	e tre	eatn	nen	t																
A copy of the patient's	con	sent	t in	writi	ng	is at	tac	hed								T2/	4 is	sig	ned	as	the	sig	nec	i co	nse	nt n	the iust
The patient signed this con-	sent	on (date	9)]/]/						Th	sta e Co	mm	issi	on:	adv	ise:	s th	at ti	he T	2A	
																	ould pat									ays	after
Notes																			-								

9

Pa	tient's Name		CHI Number		
			То	be completed by t	he DMP or RMO
Details Of Tre	atment				
he treatment of	overed by this certificate is:				
	O ECT under section 23	7(3)(a)			
	O VNS or TMS (being tr	eatments specified in r	egulations under	section 237(3)(b))	
Description of ti	ne treatment(s) including frequ	iency. The maximum du	ıration of the cou	rse of treatment autho	orised must
1					
Certification I	y RMO or DMP				
Certified by	O the RMO O the DMF	>			
Signature					
Date					
A copy of this fo	orm must be sent to the Menta	al Welfare Commission	within seven day	s of issuing the certi	ficate

Form T2B

The Mental Health (Care Certificate O			-	-					-	nt										1	Γ 2 Ι	3 (S2	40))	
Instructions																										v7.0
The following form is to b	e us	ed:																								
where the patient's RMO, of treatment under section 24 (a) any medicine (other (b) any other medicine	0(3) than	of th	e A	ct: gica	ıl imş	plan	tatio	n of	hor	mon	es)	give	n fo	r the	pun	0056	e of r	edu	cing			-		sent	for	
This form is prescribed by	y regu	latio			unde purp													Act 2	003.	The	use	of a	ny o	ther f	orm	
Where not completing this for	orm e	lect	roni	cally	, to e	ensu	ıre a	сси	racy	of in	nform	natio	n, p	leas	e ob	sen	re th	e fol	lowi	ng c	onv	entic	ns:			
Write clearly within the boxes in BLOCK CAPITALS			For	exa	mpl	e										S	hade	circ	les	like i	this	->				
and in BLACK or BLUE ink			\Box	\perp	\perp	\perp					\perp	\perp							Not.	like	this	->	×	(9	
Where a text box has a refethe box. Extension sheet(s labelled with the appropriate) sho	uld i	be c	lear	ly lai	belle	ed w																			
Patient Details																										
CHI Number			Π				Π]															
Surname		Т	\vdash		T		T	Т	\vdash	Т	\vdash	Г		Π	Г		Γ									
First Name(s)		Г	Γ		Γ		Γ			Г	Г			Г						Г				П		
Other / Known As																										
774	'Oth	er/K	nown	As' o	ouldi	includ	de an	y nan	ne / al	ias th	at the	pati	ont w	ould p	refer	to be	know	n as.		_						
Title			L										ŀ	Ger	nder		O N	1ale								
DoB dd/mm/yyyy]/]/											O F	ema	ale							
Patient's home		Г	Π		Т		Т	Г	Т	Π	Т	Г		Г			Г									
address			Г				Г				Г															
		Г	Γ		T	Г	Т	Г		Г	Τ	Г		Г	Г	Г	Г	Г	Г			Г		П		
		Г	Т		T		T	Г	T	Г	T	Т		T										П		
		\vdash	T		T		T	Т	\vdash	Т	T	\vdash		T			Г			Т				П		
Postcode		Г	T	T	T	T	T		_							L			l	I						
	_	_	_		_		_																			
The patient is detained in	n, or	und	ler t	he r	man	age	me	nt/	care	of:																
Hospital																										
Ward / Clinic																										



												Hui	nbe	L									
													То	be	co	mp	lete	ed b	y t	the	DMF	or	RMC
RMO Details (where ce	ertifica	te gr	ante	d by	the (patie	ent's	s RA	(O)														
urname	П	Т		П	T	Т	Г			П	T	Т	Т	Т	T	T	T	Т			Т	Т	7
irst Name	Ħ	÷	H	$\overline{}$	Ť	÷	Ħ		\exists	T	$\overline{}$	Ť	Ť	Ť	Ť	Ť	T	T			Ť	T	ī
itle	Ħ	Ť		\exists	Ť	÷	T	П			GN	IC N	umi	ber		ī	$\overline{}$	T	\exists		Ť	Ť	ī
iospital	苗	÷	H	H	÷	÷	÷	П	, 	\neg		\top	Т	Т	Т	Ť	Ť	∺	_	Η	$\overline{}$	\pm	i
/ard / Clinic	Ħ	Ť		\exists	Ť	÷	H		\exists	7	T	Ť	÷	Ť	Ť	Ť	T	$\overline{}$		T	寸	Ť	_
(appropriate) elephone No.	Ħ	÷	Н	\exists	÷	÷	H	Н	一	T	÷	÷	i			_	_					_	
-mail address			_	_		_			_			_	_										
		\perp	П		П	Ι			Τ			Ι		\Box	I	Ι	Ι	Ι	Ι	I	П	\top	
pproved under section 2	22 of t	he Ad	t by:																				
ealth Board NHS																							
here the patient is under th I am a child specialist; DMP Details (where cei	or (O la			child	_	cialis	st	(\$	ee r	note	s)											
-	T T	ie gr	wite.	UDy		, T	_					_	_	_	_	_	_						
Surname	H	÷	H	Н	+	÷	÷	H	Ш		-	\pm	+	+	+	井	_	_					
irst Name	\vdash	+	\vdash	Н	+	÷	÷	H	Ш		井	\pm	+	+	+	4	_	닉					
Address	Щ	+	H	Н	+	Ļ	Ļ	Ļ	Щ		_	4	+	4	4	4	_	_					
					4	Ļ	Ļ	Ļ	Щ		4	4	4	4	4	4		_					
	Щ	\pm	-				1	1															
						4					4	_	_	_	_	=	_	_					
'ostcode							GM	CN	umb	er			<u> </u>	İ	İ	Ī							
Postcode Where the patient is under the DMP am a				or	0	I, the					n NC	DT a	chik	qst	ecii	alis	t	(se	ee i	note	s)		

Patient's Name	CHI Number
	To be completed by the DMP or RMO
Certification	
Patient's consent to treatment	
, the above named RMO or DMP confirm that:	
(a) the patient is capable of consenting to the treatment;	
(b) the patient has consented in writing to the treatment (see	notes);
(c) the giving of medical treatment to the patient is authorised (Scotland) Act 2003, or the Criminal Procedure (Scotland) Act	
(d) having regard to the likelihood of its alleviating, or prevent patient's best interests that the treatment should be given to the	
Details of the patient's consent in writing to the treatment	
A copy of the patient's consent in writing is attached.	NB the patient cannot consent after the T2B is signed as the signed consent must exist at the time the T2B is completed.
The patient signed this consent on (date)	The Commission advises that the T2B should not be issued more than 7 days after the patient signs the consent form.
Details Of Treatment	
The treatment covered by this certificate is:	
 Medication to reduce sex drive - any med hormones) given for the purpose of reducin 	
 Other medication beyond 2 months - any the start of compulsory treatment (e.g. antic 	y other medicine given beyond 2 months since depressants, anxiolytics, antipsychotics etc.)
If the treatment specified is other medication beyond 2 months, record the date any medication for mental disorder was first given in this period of detention. Note that this is required only for the first T2B or T3B form for medication issued, not for subsequent forms.	Note: The period here includes an prior EDC, STDC, ICTO, CTO, TTD or orders under the Criminal Procedure (Scotland) Act 1995 which relate only to a single period of detention.

Patient's Name	CHI Number
	To be completed by the DMP or RMO
Details Of Treatment (cont)	
Description of the treatment(s) including frequency and duration of ti	ealment
Treatment can be authorised by this certificate until (date)	
Note: - the potential period of treatment authorised should be no longer than three years in line with Mental Welfare Commission for Scotlan	d recommendations
Certification by RMO or DMP	
Certified by O the RMO O the DMP	
Signature	
Date / / /	
A copy of this form must be sent to the Mental Welfare Commission	within seven days of issuing the certificate

Form T3A

Instructions																							v
The following form is to	be used	:																					
where a designated medic consenting to treatment ur (a) electro-convulsive (b) vagus nerve stimul (c) transcranial magne	cal practit nder sect therapy (lation (VN	tione tion 2 ECT; VS); a	37(3) (); and	of the		3	Note	e: EC	T, V	NS :	and i	dical MS c apab refuse	anni le of	ot b	e giv	en	7	patie	ent i	s inc	apat	ole of	
This form is prescribed for	by regulat the purpo												(Sc	otla	nd) A	kat 2	003	The	use	of a	ny ott	ner for	m
Where not completing this	form elec	ctron	ically, t	o ens	ure a	ocui	асу	of in	nform	natic	on, p	lease	obs	serv	e the	e fol	Vowi	ng c	onv	entic	ons:		
Write clearly within the boxes : BLOCK CAPITALS and in BLACK or BLUE ink Where a text box has a re			exam		Ι			1000	I	I]		[ade	-	Not	like	this	->			
the box. Extension sheet labelled with the appropris							Patie	ent's	nan	ne ar	nd C	HI nu	imbe	er, e	and e	each	n ex	tend	led i	езр	onse	shou	ld be
Patient Details									_														
CHI Number																							
Surname		Т	П		Г								Т	П	Т	П					П	Т	7
irst Name(s)		Т	П		Г	П							T	\exists	\top	\exists					\neg	\top	7
Other / Known As		\top	\vdash	\top	T	П		П	П	П		\top	\forall	\forall	\top	\forall			П	П	\neg	\top	1
	'Other /	Knawr	As' coul	d inclu	de arr	y nam	e / ali	ias the	at the	patie	nt wo	uld pre	fer to	be i	mown	185.		_					_
itle		\perp										Geno	ler	() M	ale							
OoB d/mm/yyyy]/		_ /-							L			(Fe	ma	le						
Patient's home		Т	П		Π								Т	П	П	П					П		7
ddress		†	\vdash	+	T	П			П				\forall	\forall	\forall	\forall					\exists	\top	1
		$^{+}$	\vdash	\top	\vdash	П						\top	†	\forall	\forall	\forall					\neg	$^{+}$	1
		+	\vdash	+	\vdash	Н		Н	Н			\dashv	+	\forall	+	\dashv					\dashv	+	+
		+	\vdash	+	\vdash	Н	_	Н	Н			+	+	\dashv	+	\dashv			-	-	\dashv	+	+
Postcode		+	-	+	╁	Н		Ш	Ш				_	_	_						_	_	
		_	ш			J																	
he patient is detained i	in, or un	der t	he ma	nage	me	nt/c	are	of:															
Hospital		Τ			Т									П	П	П					П	Т	7
Vard / Clinic eppropriate		İ		İ									İ	İ							Ī	İ	j
Patient's RMO		Т			\top	Т	Т	Т	Т	Т	Т	П	\neg		\neg	\neg	\neg	\neg	\neg	Т	Т	Τ	
	the second																						
Where the national is an in-		18 -											v					-					
		-	The	PMC	ie N	JULY T	20.00	ADDITION .	CIDO	arcii adii	HCT.												
Where the patient is under the RMO is a child sp		C	The	RMC	is N	TON	a c	hild	spe	ecial	ist		(se	e no	nes	- pe	age	2)					

		To be completed by the DM
MP Details		
urname		
irst Name		
ddress		
ostcode	GMC Numbe	er
O VNS or TMS (be	eing treatments specified in regulations un	der section 237(3)(b))
the patient is incapa the giving of medica Act 1995, and		
the patient is incapa the giving of medica Act 1995; and complete A or B as appropria	able of understanding the nature, purpose all treatment to the patient is authorised by the for treatments under section 237(3). Tresisting or objecting to treatment, and he	
the patient is incapa the giving of medica Act 1995; and mplete A or B as appropria the patient is NOT preventing a deter be given.	able of understanding the nature, purpose all treatment to the patient is authorised by the for treatments under section 237(3) Tresisting or objecting to treatment, and he rioration in, the patient's condition, it is in the	virtue of the Act, or the Criminal Procedure (Scotland aving regard to the likelihood of its alleviating, or he patient's best interests that the treatment should
the patient is incapa the giving of medica Act 1995; and mplete A or B as appropria the patient is NOT preventing a deter be given.	able of understanding the nature, purpose all treatment to the patient is authorised by the for treatments under section 237(3) Tresisting or objecting to treatment, and he rioration in, the patient's condition, it is in the	virtue of the Act, or the Criminal Procedure (Scotland
the patient is incapa the giving of medica Act 1995; and omplete A or B as appropria the patient is NOT preventing a deter be given. R (a) saving the p	able of understanding the nature, purpose all treatment to the patient is authorised by the for treatments under section 237(3). Tresisting or objecting to treatment, and he rioration in, the patient's condition, it is in the corresponding to treatment, and it is necessariation's life;	virtue of the Act, or the Criminal Procedure (Scotland) aving regard to the likelihood of its alleviating, or he patient's best interests that the treatment should ry to give treatment to the patient for the purpose of:
the patient is incapa the giving of medica Act 1995; and mplete A or 8 as appropria the patient is NOT preventing a deter be given. R the patient resists (a) saving the p (b) preventing s	able of understanding the nature, purpose all treatment to the patient is authorised by the for treatments under section 237(3). Tresisting or objecting to treatment, and he rioration in, the patient's condition, it is in the patient's treatment, and it is necessariation's life; serious deterioration in the patient's condition.	virtue of the Act, or the Criminal Procedure (Scotland aving regard to the likelihood of its alleviating, or the patient's best interests that the treatment should be treatment to the patient for the purpose of:
the patient is incapa the giving of medica Act 1995; and omplete A or 8 as appropria to the patient is NOT preventing a deter be given. R (a) saving the p (b) preventing s	able of understanding the nature, purpose all treatment to the patient is authorised by the for treatments under section 237(3). Tresisting or objecting to treatment, and he rioration in, the patient's condition, it is in the corresponding to treatment, and it is necessariation's life;	virtue of the Act, or the Criminal Procedure (Scotland) aving regard to the likelihood of its alleviating, or he patient's best interests that the treatment should ry to give treatment to the patient for the purpose of:

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

Patient's N	Jame	CHI Number		
etails of Treatment				
tonosinting of the tono	tmont(a) inalysting framework. The many	incom shooting of the comm	of treatment outlessing	,
escription of the trea nust be stated	tment(s) including frequency. The max	amum duration of the course	e or treatment authorised	,
Signature				
igned the DMP				
ate /mm/yyyy				
copy of this form mu	ust be sent to the Mental Welfare Com	mission within seven days	of issuing the certificate	
		,	-	

Form T3B

Instructions																									٧
The following form is to where a designated medi- consent or incapable of co (a) any medicine (of (b) any other medic (c) provision, withou	ical pract onsentin ther than tine giver	tition og un n the n be	nde su yor	r seo Irgica nd a	ction al in peri	n 24 npla od o	0(3) ntati of 2 r	of thon on	ne A f ho ths:	ot in ormo sino	rela nes e the	ation () giv e sta	en fo	he fo or the com	e pu puls	ing rpor sory	treat se of trea	red tme	nt(s) lucir): Ig se			refus	sing	
This form is prescribe	d by regu	latic										e and as be							200	3. Th	ne us	se of	any o	ther f	form
Where not completing this	s form ele	ectro	onic	ally,	toe	ensu	re a	ocui	асу	of in	nfon	matic	on, p	leas	e ob	sen	re th	e fo	Now	ing c	onv	entii	ons:		
Write clearly within the boxes	in	For example Shade circle									des	like	this	->	•		,								
BLOCK CAPITALS and in BLACK or BLUE ink			For example Shade circle.								Not	like	this	->	×		5								
the box. Extension sheet abelled with the appropri Patient Details								ith F	atie	vnt's	nan	ne a	nd C	HIn	umb	er, a	and (eac/	h ex	tend	led i	esp	onse	shou	ild bi
CHI Number											1														
Surname	\mathbb{H}	4		L		L			L	L	L	_	_	_					_		_			_	_
	\vdash	_				L			L	L	L	╀	┡						L				Н	-	4
First Name(s)	\sqcup	_				L			L	L	L	╄	╙						L				Ш	4	4
Other / Known As				Ļ	L	Ļ			L.	L	Ļ	L	Ļ	L.	Ļ	Ļ	L	L							
Title	Other	7 60	cwn	AS C	outd I	netuc	е апу	nam	6 / as	lias or	action	e pes	entw				O N		_						
DoB dd/mm/yyyy			/			/				Ė				Ger	ider		0 F								
Patient's home	П									Т	Т	Т	Т												\neg
address	\vdash			Н	\vdash	\vdash				+	\vdash	+	\vdash										Н	\rightarrow	\forall
	\vdash	+	_	Н	Н				\vdash	\vdash	\vdash	+	\vdash						\vdash		\vdash		Н	+	\dashv
	\vdash	-	_	Н	-	\vdash			\vdash	H	H	+	⊢						\vdash				Н		\dashv
	\vdash	-	_	H	_	H	_		H	⊢	H	+	⊬			-			H		-		Н	-	\dashv
Postcode	\vdash	-	_	H	_	H			_	_	_	_	_	L		L		_	L				Ш	_	
Posicode						L																			
The patient is detained	fin, or u	nde	er ti	he n	nan	age	mer	nt/	care	e of:															
Hospital		П								Г	Г	Т	Т											П	
Ward / Clinic	\Box	∺								H	H	÷	÷					=				H	П	一	Ħ
fappropriate	ш	_			_		_	_	_	_	_	-	_	_		_	_		_	_	_	_	Ш	_	
Patient's RMO																									
	r the age	of 1	18 -																						
Where the patient is unde					_		- K	ют		6.56.4		n nin	liet		196	e r	otes	2 - r	ao	21					
Where the patient is under		st	0	The	e R	MO	IS I	N)	ac	child	sp	eua	lior		700	100	to the								
		st	0	Th	e R	MO	BI	IOI	ас	chilla	sp	eula	illot.		Yar	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	10,00	o 1	9	,					

DMP Details Surname First Name Address													То	be	com	pletec	i by th	e Di
iurname irst Name iddress													<u> </u>	1]			
irst Name ddress ostcode													1	T				
ddress						+				+	L		+	+				
Postcode									#	†	\vdash	\vdash						
						+		Н	+			ш	+	$^{+}$	\dashv			
						+	+				\vdash	Н	+	+	\dashv			
				+	\rightarrow			\vdash	$^{+}$		\vdash	Н	\forall	$^{+}$	\dashv			
		+	+			+		Н	+		\vdash	Н	+	+	\dashv			
			1 1	+	+	+	\vdash	H	+	+	\vdash	Н	+	+	\dashv			
Where the patient is und			+	+	GI	MC N	lumb	er	+	+	\vdash	Н	+	$^{+}$	\dashv			
where the patient is und											_	ш						
I, the above DMP :			et: or	0.1	the r	elbor ii	. DW	Dam	. NIC	OT a c	hild	ena	ialie		/eee	natos	below	٨
·	an a cilica	speciali	SI, UI	01,	uie	abovi	S DW	ir aii	140	/ a c	HIIIG	sper	Jidilə		(000	INVO	Delow	,
ERTIFICATION																		
he treatment covere	d by this or	ertificate	e is:															
Other medicat compulsory trea Artificial nutrit patient	ion beyond itment (e.g	d 2 mo	pressa	ants, a	inxiol	ytics,	antij	osych	otic	s etc.)							
,																		
the above named D			-															
the giving of med Act 1995; and	ical treatme	ent to tr	ne patie	ent is	autho	nsec	i by v	virtue	of tr	ne Ac	t, or	tne	Srim	inal	PTOC	edure	(Scott	and,
having regard to patient's best inte	rests that t	he treat	tments	shou	ld be	give	n; an	d				e pa	rtient	's c	ondit	ion, it	s in the	е
O the patient is o							it do	es no	t co	nsent	, or							
O the patient is in	capable of	conser	nting to	the to	reatm	ent;												
he patient is capable	of consen	ting, bu	t is ref	using	cons	ent, d	omp	elete r	eas	ons v	vhy t	he tr	eatn	nent	shou	uld be	given.	
1																		

....

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

	Patient's Name			CHI Number		
					To be completed	by the DMP
Details	s of Treatment					
	reatment specified is	other medication			Note: The period here	includes any
beyond medica in this require	d 2 months, record th ation for mental disord period of detention. Ned only for the first T2! ation issued, not for si	e date any der was first given lote that this is B or T3B form for	/ 🗔	/	prior EDC, STDC, ICTC or orders under the Crin Procedure (Scotland) A relate only to a single p detention	o, CTO, TTD ninal at 1995 which
		s) including frequency and	duration of tre	atment		
2						
Trea	itment can be authori:	sed by this certificate until	(date)	/		
	the description o - for certificates as	uthorising nutrition by artificial in if treatment above, uthorising medication, the poten in line with Mental Wetfare Con	itial period of treat	ment authorised sh	ould be no longer	
Signat	ture					
Signed by the Di	MP					
Date dd/mm/y						
		ent to the Mental Welfare	Commission	within seven day	s of issuing the certificat	te

EXPLANATORY NOTE

(This note is not part of the Regulations)

These Regulations revoke and replace the Mental Health (Certificates for Medical Treatment) (Scotland) Regulations 2005 and the Mental Health (Certificates for Medical Treatment) (Scotland) Amendment Regulations 2008.

These Regulations prescribe the forms to be used, and the particulars of those forms, in giving certificates required under sections 235, 236, 238, 239 and 241 of the Mental Health (Care and Treatment) (Scotland) Act 2003.