Queensland Government

Mental Health Act 2016

Certificate to Perform Emergency Electroconvulsive Therapy (ECT)

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

Mental Health Act (MHA) 2016, Sections 237

- Electroconvulsive therapy may only be performed at an authorised mental health service (AMHS) in an emergency if:
  - the person is subject to a treatment authority, treatment support order, forensic order or a person absent without permission from another State detained in an AMHS;
  - a certificate to perform emergency electroconvulsive therapy is in force; and
  - an application has been made to the Mental Health Review Tribunal to perform electroconvulsive therapy and is not decided.

1. Person's details

- Not required if label affixed in top right corner.

Surname:	Given name(s):		
Residential address:			
Town / Suburb:		State:	Postcode:
Date of birth: Age: or	Sex: ☐ Male ☐ Female ☐ Intersex / Indeterminate ☐ Not stated / unknown		

2. MHA status

Name of AMHS:

MHA status: ☐ Treatment authority ☐ Forensic order ☐ Treatment support order ☐ Detained from interstate

3. Reasons

- Provide reasons that you believe the performance of emergency electroconvulsive therapy is necessary to:
  - save the patient's life; or
  - prevent the patient from suffering irreparable harm.

DO NOT WRITE IN THIS BINDING MARGIN

CERTIFICATE TO PERFORM ECT

v1.00 - 01/2017

SW730

Queensland Government

Mental Health Act 2016

Certificate to Perform Emergency Electroconvulsive Therapy (ECT)

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

4. Certification of Doctor and Senior Medical Administrator

• The certifying Senior Medical Administrator MUST be a different person to certifying Doctor.

• *The patient is an involuntary patient of the type specified in Section 2.*
• *It is necessary to perform emergency electroconvulsive therapy to save the patient's life or prevent the patient from suffering irreparable harm.*
• *An application to perform electroconvulsive therapy has been made to the Mental Health Review Tribunal and has not been decided.*

Doctor's name:	Designation:	Signature:	Date:	Time (24hr):
Senior Medical Administrator's name:	Designation:	Signature:	Date:	Time (24hr):

TO: AMHS Administrator (AMHS Administrator to forward to Mental Health Review Tribunal)

DO NOT WRITE IN THIS BINDING MARGIN