CERTIFICATES FOR ELECTRO CONVULSIVE THERAPY (ECT)

(Mental Health Act 2007 – s. 93-94)

Name of the Mental Health Facility: _____

Medical Practitioner/Psychiatrist/Psychiatrist with expertise in treating children/adolescents

I, Dr ……., am of the opinion that Electroconvulsive Therapy is a reasonable
(Please print your name)

and proper treatment to be administered to ……. and (*) necessary /
(Name of Patient in full)

desirable for (*) his / her (*) safety / welfare. I make this statement after considering the patient's clinical

condition, history of treatment and any appropriate alternative treatment

(*) ***Strike out inapplicable word***

Comments : ……..

……

……

Signature: ……..

Print Name ……..

Qualifications ……

Date ……/……../……..

Medical Practitioner/Psychiatrist/Psychiatrist with expertise in treating children/adolescents

I, Dr ……., am of the opinion that Electroconvulsive Therapy is a reasonable
(Please print your name)

and proper treatment to be administered to ……. and (*) necessary /
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condition, history of treatment and any appropriate alternative treatment

(*) ***Strike out inapplicable word***

Comments : ……..

……

……

Signature: ……..

Print Name ……..

Qualifications ……

Date ……/……../……..

Applications to the Mental Health Review Tribunal must be supported by recommendations of two Medical Officers at least one of whom is a psychiatrist. If the patient is under the age of 16 then at least one of the certificates must be completed by a psychiatrist with expertise in the treatment of children or adolescents.