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| --- | --- | --- | --- | --- |
| RMO’s Name: |  | | Date: |  |
| Patient’s Name: |  | | CHI: |  |
| Address: |  | | | |
| Named Person: |  | | Named person contact: |  |
| Advance Statement: | Yes/No | Location of Advance Statement: | |  |
| **Clinical Summary:** | | | | |
| Background and Psychiatric History: | | | | |
|  | | | | |
| Current Mental State: | | | | |
|  | | | | |
| Diagnosis: |  | | | |
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| Does the treatment plan include high dose or off licence prescribing? | | | | Yes/No |
| If yes, please provide treatment review or summary: (or attach additional information) | | | | |
|  | | | | |
| **Date treatment first given (if this is the first treatment certificate):** | | | |  |
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| **Treatment Plan (Please only record treatment to be authorised by DMP under Part 16):** | | | | |
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| Signed by RMO: |  | | | |