

The Mental Health (Care and Treatment) (Scotland) Act 2003 / The Criminal Procedure (Scotland) Act 1995

**Second Opinion Request** 

SOP 1

Instructions	v7 1

The following form is to be used to request the Mental Welfare Commission to arrange a second opinion visit:

Patient Details																										
CHI Number																										
Surname [																										
irst Name (s)																										
DoB d / mm / yyyy			/			/																				
Patient's home address																										
		T																T			Ť					
		T																T			İ					
																					Ť	Ī				
Postcode									•				•			•	•	•								•
If under 18, is the RMO a	ch	ild s	spe	cialis	st?	(lea	ve b	_ lanl	c if r	not :	unde	r 18	3) (	) <b>Y</b> (	es	0	N	0								
Does patient have learnir			-			() Y			0				,													
																							$\neg$			
Current order (e.g. STDC	or	СТ	O)																							
Date this MHA episode co episode e.g. EDC, STDC		mei	nce	d (i.e	e. da	ate (	of th	ie fii	rst c	orde	er in t	his						/ [			/[					
Hospital																										
Ward / Clinic					$\perp$										+											
																					 ]					
Direct phone number of the	he	Wa	rd/ (	Clini	c:																					
Details of visit location if not	ak	noer	nital	e 0	clini	c/ re	ווספי	rce i	cent	re.																
If the visit can only be done											ist the	na -	me	cor	itact	tele	nhc	ne i	าเเท	her	anı	d e	mai	l ac	ldres	39.0
appropriate staff escort to a	cco	mpa	any	the D	MP	, e.g	g. CF	PN, 9	socia	al w	orker	, su	ppo	rt wo	rke	r.	рпс	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			an	u c		- ac		
CPN name and contact deta	ails	(if a	ppli	cable	e)																					
Alle and and the second							_,.																			
Where are the patient's med	dica	ı re	cord	s an	d m	edic	atior	n pre	escri	ptio	n she	et I	oca	ted?												



Please list any specific visit requests/information, e.g. time of visit, risk issues including whether the DMP would need a staff escort, or if a translator is required. Please also add name, contact telephone number and email address of anyone other than the RMO who can help facilitate this visit (e.g. CPN, ward charge nurse, secretary).								
Note: if a translator is required, this will need to be arranged by you or your team. Pl visit.	lease co-ordinate the translator with the DMP's							
Timescale for visit ○ 2 weeks (Meds) ○ 7 - 10 days (ECT or artificial nut	rition e.g. by NG or PEG)							
We endeavour to arrange a face to face Designated Medical Practitioner (DN arranged. However in some circumstances it may be appropriate and/or nec								
The following questions will assist the MWC if a remote assessment is being	considered:							
Do you (as the RMO) think a remote assessment is suitable? O Yes O	No							
If there anything else that might assist in determining method of assessment	, please mention this here:							
	○ Yes							
Would this patient be willing and able to engage with a remote assessment?	O No							
	○ Don't know							



Treatment
For medication to reduce sex drive? O Yes O No
(T3B required from the beginning of treatment other than for urgent treatment given under s243.)
For other medication (i.e. medication other than medication to reduce sex drive)? O Yes O No
If there is a T3B currently in place for such medication, please enter the expiry date of that T3B:
Is Clozapine one of the treatments? O Yes* O No * If Clozapine, what route is it to be given? (leave blank if no)
For ECT? O Yes O No If ECT is it for "maintenance ECT"? O Yes O No
(T3A required from the beginning of treatment other than for urgent treatment given under s243.)
Artificial nutrition e.g. by NG or PEG? O Yes O No
(T3B required from the beginning of treatment other than for urgent treatment given under s243.)
If there is a T3B for artificial nutrition currently in place, please enter the expiry date:
Medication beyond 2 months - medication other than medication to reduce sex drive
If the request is for medication (other than medication to reduce sex drive), will this be the first T2B or T3B in the current Mental Health Act (MHA) episode?
If yes, what was the first date on which any medication was administered to the patient as mental health treatment after the current MHA episode started (medication other than medication to reduce sex drive). If the MHA episode started with an EDC, medication given during the EDC period counts.
(This is important. We need to know this. The first T2B or T3B for medication other than medication to reduce sex drive is due two months after this date. The DMP is required to put this date on the T3B if there has not already been a T2B or T3B in the MHA episode for medication beyond 2 months.)
We would like to receive the SOP1 form to request for a DMP visit (for first T3B) at least 14 days before the T3B is due. This will give us time to arrange the DMP visit. We can accept the SOP1 up to 21 days before the T3B is due.
If this request is for medication and there is an existing T3B for medication in place, does the medication you are asking the DMP to consider authorising include any medication that is not currently covered by that T3B?
If so, please list that medication. (If this is not applicable, please leave blank and go to the next section.)
If this request includes depot antipsychotic that the patient is already receiving, when is the next dose of their depot due?



ivame and com	act details of any Named Person
	act details of any welfare proxy (i.e. active welfare power of attorney that is operational or n). Leave blank if none.
Does patient ha	ve an Advance Statement? O Yes O No
Date of Advanc	e Statement / / / / / / / / / / / / / / / / / / /
_ocation of any	Advance Statement
	that case notes, prescription sheet, current treatment certificate O Yes O No and MHA documentation are available for the DMP
What action has	been taken to confirm this?
Clinical Sumr	nary
Background and	d Psychiatric History
Current Mental	State
Diagnosis/diag	noses (It patient has learning disability, please describe their level of learning disability and
Diagnosis/diag their ability to c	noses (If patient has learning disability, please describe their level of learning disability and ommunicate. This will help us to allocate the visit to a DMP.)
Diagnosis/diag their ability to c	noses (It patient has learning disability, please describe their level of learning disability and ommunicate. This will help us to allocate the visit to a DMP.)



Report by RMO for Design	nated Medical Practitioner (cont.)
Does the treatment plan inc	lude high dose or off-licence prescribing? O Yes O No
documentation in relation to	this treatment and the rationale for the request. Please refer here to any this decision that the DMP should see, and make these documents available for s, pharmacy reviews, specialist opinions etc). Thank you.
• • • • • • • • • • • • • • • • • • • •	complete applicable sections)
Treatment plan if request is	for medication
Treatment plan if request is	for FCT
Treatment plan in request is	
Treatment plan if request is	for artificial nutrition
RMO Details	
Surname	
First Name	
RMO Mobile telephone no:	
Email address	
Date SOP form completed	

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