

MEOS CARD

**Form T2** Regulation 27(2)

**Mental Health Act 1983**

**Section 58(3)(a) – certificate of consent to treatment**

I (PRINT full name and address)

**Dr Vijay Simha Pandrapragada**  
**C/O: St Augustine's Hospital, Cobridge Road, Stoke-on-Trent,**  
**Staffordshire**  
**ST1 5JY**

the approved clinician in charge of the treatment described below / ~~a registered medical practitioner appointed for the purposes of Part 4 of the Act (a SOAD)~~ (delete the phrase which does not apply) certify that

(PRINT full name and address of patient)

**C/O: St Augustine's Hospital, Cobridge Road, Stoke-on-Trent,**  
**Staffordshire**  
**ST1 5JY**

(a) is capable of understanding the nature, purpose and likely effects of: (Give description of treatment or plan of treatment. Indicate clearly if the certificate is only to apply to any or all of the treatment for a specific period)

BNF Category Tick as appropriate ✓	Route (Po I/m I/V)	No. of preparations	Reg	PRN	Within BNF Limits	Notes or name of specific medication
Antipsychotics 4.2.1 Including/ <del>not including</del> Clozapine			<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Antipsychotic Depot Injection 4.2.2			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Antimanic drugs 4.2.3			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Antidepressant 4.3			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Anticholinergic drugs 4.9.2			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tetrabenazine 4.9.3			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CNS stimulants / drug for ADHD 4.4			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Antiepileptic used as mood stabilisers 4.8.1			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Antiepileptic used as anxiolytics 4.8.1			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Drugs used in substance abuse 4.10			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hypnotics 4.1.1			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Anxiolytics 4.1.2			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Drugs for dementia 4.11			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other <i>Pimozine</i>			<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

(If you need to continue on a separate sheet please indicate here [ ] and attach the sheet to this form)

AND

(b) has consented to that treatment

Signed:

*Dr Vijay Pandrapragada*  
**Dr Vijay Pandrapragada**  
Responsible Clinician

Date:

*07/01/14*

**Section 58 (3) (b) – certificate of second opinion**

**I (PRINT full name and address)**

**KISHORE CHANDIRAMANI  
C/O CQC MENTAL HEALTH ACT, CITYGATE, GALLOWGATE, NEWCASTLE-UPON-  
TYNE, NE1 4PA**

**a registered medical practitioner appointed for the purposes of Part 4 of the Act (a SOAD),  
have consulted**

**(PRINT full name of nurse)**

**Elise Cameron**

**a nurse and**

**(PRINT full name and profession)**

**Sarah Greenhaf, Psychologist**

**who have been professionally concerned with the medical treatment of**

**(PRINT full name and address of patient)**

**c/o St Augustine's Hospital  
Cobridge Road, Stoke on Trent ST1 5JP**

**I certify that the patient – (Delete the phase which does not apply)**

- (a) is not capable of understanding the nature, purpose and likely affects of**  
**(b) has not consented to**

**the following treatment**

**(Give description of treatment or plan of treatment. Indicate clearly if the certificate is only to apply to  
any or all of the treatment for a specific period)**

- 1. Up to two antipsychotic drugs BNF 4.2.1 including clozapine oral/im. Total  
combined dose of all antipsychotic drugs not to exceed the equivalent of BNF  
limit of one antipsychotic drug**
  - 2. One antimanic drug BNF 4.2.3 as a mood stabiliser orally**
  - 3. One antiepileptic drug BNF 4.8.1 as an adjunct to antipsychotics orally**
- 2 and 3 to be within BNF limits**

**but that it is appropriate for the treatment to be given.**

NHS NUMBER

SURNAME

FIRST NAME

DATE OF BIRTH

HOSPITAL

CONSULTANT

25/12/93  
St Augustine's  
Dr [Signature]

## PHOTOGRAPH

☐ IN FILE☐ REFUSED

MULTIPLE MEDICATION CHARTS

4 OF 1



Cambian

## MHA STATUS

☐ Informal☒ Formally Detained☐ MHA Documentation attached

## DRUG ALLERGIES AND SENSITIVITIES

KNOWN Prescriber's Signature \_\_\_\_\_ Date \_\_\_\_\_

NONE KNOWN

Drug / Allergen

Description of Reaction

Prescriber's Signature \_\_\_\_\_

Date

24/2/14

## PRESCRIPTIONS FOR ONCE-ONLY OR PATIENT GROUP DIRECTION MEDICATION

DATE	MEDICINE AND FORM (APPROVED NAME)	DOSE	ROUTE	TIME TO BE GIVEN	SIGNATURE	DATE	TIME GIVEN	GIVEN BY	CHECKED BY
25/2/14	Haloperidol	2.5	oral	1700	[Signature]	25/2/14	1750	85	
26/2/14	Haloperidol	5mg	oral	1300	[Signature]	26/2/14	1305	CB	
26/2/14	Sami Sodium Valproate	1g	oral	1300	[Signature]	26/2/14	1305	CB	
26/2/14	Clozapine	12.5mg	oral		[Signature]				

## DEPOT INTRAMUSCULAR PREPARATIONS

DATE	MEDICINE (APPROVED NAME)	DOSE	FREQ	INI SITE	PREScriBER'S SIGNATURE	DATE	TIME GIVEN	GIVEN BY	SITE (L or R)	DATE NEXT DUE	DATE	TIME GIVEN	GIVEN BY	SITE (L or R)	DATE NEXT DUE

## VARIABLE DOSE AND TITRATION REGIMENS

MEDICINE AND FORM	DATE	25/2/14	26/2/14	27/2/14	28/2/14	1/3/14	2/3/14	3/3/14
Clozapine								
ROUTE	DATE	Time	Dose	Given	Dose	Given	Dose	Given
oral	25/2/14	900			12.5mg	4	25mg	25mg
SIGNATURE		2/100	12.5mg	80M	12.5mg	20	25mg	50mg
MEDICINE AND FORM	DATE	4/3/14	5/3/14	6/3/14	7/3/14	8/3/14	9/3/14	10/3/14
Clozapine								
ROUTE	DATE	Time	Dose	Given	Dose	Given	Dose	Given
oral	4/3/14	900	50mg		75mg		75mg	
SIGNATURE		2/100	75mg		75mg		100mg	

## ENSURE:

- All patient details are complete
- Drug allergy and sensitivity box is complete
- Medicine names are written clearly, legibly in **CAPITAL LETTERS** and using approved names
- Ensure the dose form is stated (e.g. tablet, oral solution, M/R tablet)
- The route, dose and time to be given are clearly stated
- All items are signed by a registered prescriber
- A start date is entered. The start date must relate to the start date of the drug, not the prescription chart.
- Drugs are stopped by completing the stop date and diagonally crossing through the entire administration box.

## COPYRIGHT

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**SPEEDS**  
HOSPITAL  
PHARMACY

Telephone: 0843 506 55 66

PATIENT'S NAME:

## NON-ADMINISTRATION OF MEDICINES

When a patient does not receive a prescribed dose, the nurse should enter a code number from the key below in the administration box, to explain the reason for non-administration. Ensure an entry is made in the patient's notes.

- |                     |                               |                         |                               |                    |
|---------------------|-------------------------------|-------------------------|-------------------------------|--------------------|
| 1. Absent From Unit | 3. Patient On Leave           | 5. Patient Sleeping     | 7. Withheld                   | 9. Self-medicating |
| 2. Fasting          | 4. Patient Refused Medication | 6. Patient Unobtainable | 8. Medication Given Elsewhere |                    |



**WHEN REQUIRED MEDICATION (PRN)**

DATE

PATIENT'S NAME: .....

DATE	TIME GIVEN	DOSE	GIVEN BY	DATE	TIME GIVEN	DOSE	GIVEN BY	DATE	TIME GIVEN	DOSE	GIVEN BY
------	------------	------	----------	------	------------	------	----------	------	------------	------	----------

DATE 24/1/14		MEDICINE (Approved Name) AND FORM <b>Haloperidol</b>						28/2/14 17.30 5mg CB			
DOSE 5mg		ROUTE oral		DOSE FREQUENCY 5mg / 8h							
PRESCRIBER'S SIGNATURE 				MAXIMUM TOTAL DOSE IN 24 HOURS 20mg / 24h							
				INDICATION inc. regular psychosis + agitation							
SPECIAL INSTRUCTIONS / ADDITIONAL INFORMATION 20mg/day max. including regular.		STOCK BALANCE⇒									
DATE 14/1/14		MEDICINE (Approved Name) AND FORM <b>Lorazepam</b>									
DOSE 1-2mg		ROUTE oral		DOSE FREQUENCY 1-2mg / 4h							
PRESCRIBER'S SIGNATURE 				MAXIMUM TOTAL DOSE IN 24 HOURS 4mg / 24h							
				INDICATION agitation							
SPECIAL INSTRUCTIONS / ADDITIONAL INFORMATION		STOCK BALANCE⇒									
DATE 14/1/14		MEDICINE (Approved Name) AND FORM <b>Lorazepam</b> , 1m									
DOSE 1-2mg		ROUTE 1m		DOSE FREQUENCY 1-2mg / 4h							
PRESCRIBER'S SIGNATURE 				MAXIMUM TOTAL DOSE IN 24 HOURS 4mg / 24h							
				INDICATION agitation							
SPECIAL INSTRUCTIONS / ADDITIONAL INFORMATION only if oral refused		STOCK BALANCE⇒									
DATE		MEDICINE (Approved Name) AND FORM									
DOSE		ROUTE		DOSE FREQUENCY							
PRESCRIBER'S SIGNATURE				MAXIMUM TOTAL DOSE IN 24 HOURS							
				INDICATION							
SPECIAL INSTRUCTIONS / ADDITIONAL INFORMATION		STOCK BALANCE⇒									
DATE		MEDICINE (Approved Name) AND FORM									
DOSE		ROUTE		DOSE FREQUENCY							
PRESCRIBER'S SIGNATURE				MAXIMUM TOTAL DOSE IN 24 HOURS							
				INDICATION							
SPECIAL INSTRUCTIONS / ADDITIONAL INFORMATION		STOCK BALANCE⇒									

NHS NUMBER

SURNAME

FIRST NAME

DATE OF BIRTH

HOSPITAL

CONSULTANT

16/3/84  
St Augustine  
Pandrangoda

## PHOTOGRAPH

☐ IN FILE☐ REFUSED

MULTIPLE MEDICATION CHARTS

2 OF 2



Cambian

## MHA STATUS

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## DRUG ALLERGIES AND SENSITIVITIES

KNOWN Prescriber's Signature \_\_\_\_\_ Date \_\_\_\_\_

NONE KNOWN

Drug / Allergen

Description of Reaction

Prescriber's Signature

Date

Asad  
2/1/14

## PRESCRIPTIONS FOR ONCE-ONLY OR PATIENT GROUP DIRECTION MEDICATION

DATE	MEDICINE AND FORM (APPROVED NAME)	DOSE	ROUTE	TIME TO BE GIVEN	SIGNATURE	DATE	TIME GIVEN	GIVEN BY	CHECKED BY
12/1/14	CLONAZEPAM TABLET	1mg	O	13.00		12/1/14	13.00	AB	

## DEPOT INTRAMUSCULAR PREPARATIONS

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## VARIABLE DOSE AND TITRATION REGIMENS

MEDICINE AND FORM	DATE	Dose	Given	Dose	Given	Dose	Given	Dose	Given	Dose	Given	Dose	Given	Dose	Given	Dose	Given
ROUTE	DATE																
SIGNATURE																	

  

MEDICINE AND FORM	DATE	Dose	Given	Dose	Given	Dose	Given	Dose	Given	Dose	Given	Dose	Given	Dose	Given	Dose	Given
ROUTE	DATE																
SIGNATURE																	

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