Appendix 4 – Best interest decision record form

Please provide a copy of this form to the carer(s) supporting the patient and scan into patient notes in surgery.

Name of patient			
Date of birth		Location	

-What treatment is being considered for covert administration? *(Consider inclusion of acute treatments for emergencies e.g., Antibiotics, Lorazepam)* **It has been confirmed that no advanced decisions are in place concerning this treatment.**		
-Why is this treatment necessary? -How will the person benefit? -Could this treatment be stopped? Where appropriate, refer to clinical guidelines, e.g., NICE.		
-What alternatives did the team consider which were not successful? Examples - other ways to manage the person, other ways to administer treatment, different formulations such as liquids or dispersible tablets -Why were they not appropriate?	State the options tried:	
Treatment may only be considered for a person who lacks capacity. -When was Mental Capacity Assessment (MCA) for this issue completed?	Date:	
	Assessed by:	Name: Signature:
-Who was involved in the decision? N.B. A pharmacist must give advice on administration if this involves crushing tablets or combining with food and drink as it may be unsuitable (see Appendix 5) **If there is any person with Lasting Power of Attorney to consent, then the treatment may only be administered covertly with that person's consent, unless this is impracticable.**	Name of health care professionals involved:	
	Name of relatives, advocates or other carers involved:	
-When will the need for covert treatment be reviewed? (This will be dependent on physical condition of each patient. Fluctuating capacity requires more frequent review - at least every three months)	Date of first planned review	

Important – please note that covert administration usually involves altering medicines and this may be <u>unlicensed</u> (off-label) activity. By signing this form the prescriber is also authorising unlicensed (off-label) use of medication. At present this can only be done by an independent prescriber.

Prescriber name:	
Signature:	
Date:	