

Ceasing from Cervical Screening Programme – Mental Capacity Act (MCA)

Please do not send the woman named below any further invitations to participate in the NHS Cervical Screening Programme. I understand that the woman named below can be restored to the screening list at any time.

Patient Name			
Patient NHS Number			
Patient Date of Birth			
Patient Address			
Patient Representative or Carer Details			
Name			
Address			
Signature		Date	

Declaration

I assume full responsibility for this decision in a Best Interest Capacity in line with the Mental Capacity Act. I have made the decision after taking the following actions:

1. Discussion with the individual to assess capacity
2. Discussion with the patient representative or carer of the patient including the benefits and disadvantages of cervical screening and the importance of screening in the prevention of cervical cancer
3. Discussion with other members of the care team and/or family members/carers (please specify who):

I confirm that that the situation will be reconsidered if the patient’s personal circumstances change.

RESPONSIBLE CLINICIAN signature: _____

NAME (printed): _____ DATE: _____

RESPONSIBILITY TO PATIENT: _____

ORGANISATION NAME: _____ NATIONAL CODE: _____

ORGANISATION ADDRESS: _____

Next Steps

Next steps for Practices: Once completed and signed, please upload this form via the CSAS website. You should use the online enquiry form on the ‘Contact Us’ page and select the ‘Cease’ option. Keep the original copy in your files.

Next steps for other organisations: Once completed and signed, please upload this form via the CSAS website. You should use the online enquiry form on the ‘Contact Us’ page and select the ‘General Enquiry’ option, adding ‘Cease Request’ in the ‘Type of query’ text field. Keep the original copy in your files.