LIMITATION OF CONSENT TO TREATMENT FOR PATIENT WITH ME/CFS

NB: please read Guidance Notes before using this form

Complete this form before your appointment and keep a copy. Take this form with you so you can show it to your doctor if you become concerned about the direction of the appointment.

Patient's name _____

Address _____

Date of birth _____

PATIENT STATEMENT: I was diagnosed with the illness ME/CFS (myalgic encephalomyelitis/chronic fatigue syndrome) as defined in the NICE guideline NG206 of 29 October 2021.

[Complete where possible] This diagnosis of ME/CFS was made on _____ at _____ by_____

I consent to be seen and treated only by healthcare professionals who are familiar with the above NICE guideline and who understand that ME/CFS:

a) is "a fluctuating medical condition" *[para 1.6.4]*

b) is not appropriate for treatment with graded exercise

therapy *[para 1.11.14]*

c) is not appropriate for treatment with cognitive behavioural therapy other than as a purely supportive treatment *[para 1.12.28]*

d) must not be treated with the Lightning Process or other similar therapies *[para 1.12.27]*

e) is an illness where the most severely affected patients *"may not be able to swallow and may need to be **tube fed**" [page 8]*

I do not consent to be seen or treated by any healthcare professional who treats ME/CFS primarily as a psychiatric, psychosocial, medically unexplained, functional neurological or other similar disorder.

If I am referred to, or seen by, any such professional, then my consent to treatment is withdrawn immediately.

Name_____ *[patient/parent/carer]*

Signature & date_____

Ref: LoCformApril2022VES