(Affix patient identification label here)

URN:

Family Name:

Given Names:

Date of Birth: Sex: ☐ M ☐ F

FM 393 **ECT CONSENT AND TREATMENT RECORD**

Commencement Date: ____________

Completion Date: ____________

CONSENT FOR ELECTROCONVULSIVE THERAPY (ECT)

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Date of Birth: Sex: ☐ M ☐ F

ELECTROCONVULSIVE TREATMENT (ECT)

ECT is given under a general anaesthesia. A muscle relaxing drug is given once the patient is asleep, to limit body movement. During ECT, electrodes are put onto the scalp and an electric current is passed briefly through the electrodes to the brain, which causes modified seizure activity. Consent is given for a specified number of treatments in one course. Further courses require a new consent form to be completed.

Acute ECT is a course of treatments given two or three times per week to treat an episode of acute illness.

Maintenance / Continuation ECT is the use of ongoing ECT treatments (between weekly and monthly) to remain well.

RISKS

These are the most common risks. There may be other unusual risks that have not been listed here. Please ask your psychiatrist if you have any general or specific concerns.

- I understand there are risks associated with an anaesthetic.
- I may have side effects from any of the anaesthetic drugs used. The most common side effects include lightheadedness, nausea and muscle soreness.
- I understand the procedure has the following specific risks and limitations:

  Immediately after treatment

  - I may feel nauseated, have some muscle soreness and/or have a headache.
  - I may be somewhat confused for a period (usually minutes to hours).
  - There is a very small risk of musculoskeletal injury.
  - Sometimes dental and oral problems can occur.
  - I may have heart rhythm or blood pressure changes, but these will be monitored closely during and after the procedure and treated if necessary.

  Later consequences

  - I may have short term memory difficulties for some time after the procedure, and find it difficult for example to remember recent conversations or things I have just read.
  - I may also have some difficulty remembering past events, such as dates, names of friends, phone numbers, PIN numbers or passwords. If this affects me, it usually will be mild but may last for an unpredictable length of time.
  - Some people complain of more severe memory loss, which is generally confined to the period around the time of the ECT treatment. In some people, loss of older memories may be severe and can even be permanent. There is no clear evidence that individuals' ability to construct new memories is affected in the long term.
  - There is an extremely small risk of death from the procedure.
- I understand some of the above risks are more likely if I smoke, am overweight or have medical problems such as heart disease, high blood pressure or diabetes.

CONSENT FOR ELECTROCONVULSIVE THERAPY (ECT)

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Date of Birth: Sex: ☐ M ☐ F

DECLARATION BY PATIENT

- I acknowledge that the psychiatrist has informed me and provided me with written information and access to other media about the procedure and answered my specific queries and concerns about this treatment.
- I acknowledge that I have discussed with the psychiatrist any significant risks and complications specific to my personal circumstances that I have considered in deciding to have this treatment.
- I understand that I can change my mind at any stage, even after a course of treatment has begun, without affecting my future health treatment, or any other treatment of the condition for which ECT has been proposed.
- I have not been guaranteed the treatment will be successful, and I understand the treatment is not a long term cure for the condition, so I may still relapse in the future.
- I have received a copy of this form.
- If a needle stick or sharps injury occurs to staff during any operation, I give my permission for blood to be taken and tested for HIV and other blood borne disorders. I understand that I will be advised and counselled as soon as practicable after the treatment if this has been necessary.
- Other: ____

I declare that all of the above information and information overleaf has been explained to me by my treating psychiatrist. I consent to a course of up to ___________________________ treatments of ☐ acute OR ☐ maintenance/ continuation ECT (please tick the type of treatment to be received)

Patient's Full Name: ___________________________ Patient's Signature: ____________________________

Date: __________________

Witness Name: _______________________________ Witness Signature: ____________________________

DECLARATION BY DOCTOR

- I declare that I have explained the nature and consequences of ECT and discussed the benefits and risks that particularly concern the patient.
- I have given the patient, and the patient's carer where involved, an opportunity to ask questions and I have answered these. I confirm that I have explained the nature and effect of this treatment to the above patient.

Psychiatrist Name: ____________________________ Psychiatrist Signature: __________________________

Date: __________________

tph Toowong Private Hospital

ELECTROCONVULSIVE THERAPY (ECT) TREATMENT RECORD

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Date of Birth: Sex: ☐ M ☐ F

Date	Course	No.	Induction / Relaxant			ASA	Anaesth Signature	Electrode Placement	Pulse Width	Dose	Outcome / Morphology*						PSI	Psych Signature
			Propofol	Sux	Other						Duration	P	F	G	E	Comments		

* Morphology: P = Poor, F=Fair, G=Good, E=Excellent

Last Reviewed 011/2016 For Review 07/2020