

Affix Hospital Identification Here Consent form for electroconvulsive therapy (ECT) (page 1 of 2)	SURNAME		UMRN
	GIVEN NAMES		DOB
	ADDRESS		
	SUBURB		POSTCODE

This form is to be completed giving due consideration to the -
 “Consent to Treatment Policy for the Western Australian Health System”

PROPOSED TREATMENT

Electroconvulsive therapy is proposed for *(name of patient)* _____
 for the following reasons *(doctor to list reasons)*: _____

ELECTROCONVULSIVE TREATMENT (ECT)

ECT is given under a general anaesthesia, so the patient is asleep during the treatment and will not feel or remember anything. During ECT, electrodes are put onto the scalp and an electric current is passed briefly through the electrodes to the brain, which causes a seizure (a ‘fit’). A muscle relaxing drug is given once the patient is asleep, to limit body spasms. Consent is given for a specified number of treatments in one course. Further courses require a new consent form to be completed.

RISKS

These are the commoner 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 any anaesthetic *(see separate Anaesthetic Consent Form)*.
- I understand that I may have side effects from any of the drugs used. The commoner side effects include light-headedness, nausea, skin rash and constipation.
- 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 will probably be somewhat confused.
 - With modern techniques, there is a very small risk of bone fractures or dislocations.
 - 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. If this affects me, it may be mild and may last for an unpredictable length of time. In some people, memory loss may be severe and can even be permanent.
 - Some people complain of more severe memory loss, which is generally confined to the period around the time of the ECT treatment. There is no 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 heart disease, high blood pressure or diabetes.

DISCLOSURE OF MATERIAL RISKS (to be completed by psychiatrist if necessary)

I understand the following are possible significant risks and complications specific to my personal circumstances, that I have considered in deciding to have this treatment: _____

MR 30.6 CONSENT FORM FOR ELECTROCONVULSIVE THERAPY (ECT)

DECLARATION BY PATIENT

- I consent to a course of _____ treatments (*patient to complete number of treatments; maximum 12*)
- I acknowledge the psychiatrist has informed me and provided me with written information about the procedure, available alternative treatments 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 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 future.
- I understand that a doctor other than the specialist psychiatrist may perform the procedure. The doctor treating me will have been appropriately trained in the technique.
- I have received a copy of this form.
- If a needlestick/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 I will be advised and counselled as soon as practicable after the treatment if this has been necessary.

Patient's Full Name _____ Patient's Signature _____ Date/Time _____

Witness to the patient's signature. Name and signature of witness _____

Advocate/Carer's Signature _____ Date/Time _____

Relationship to Patient _____

DECLARATION OF DOCTOR

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

FULL NAME (please print) _____ POSITION/TITLE _____

SIGNATURE _____ DATE _____

INVOLUNTARY PATIENT OR MENTALLY IMPAIRED ACCUSED (where applicable)

The treatment has been recommended by the treating psychiatrist and the recommendation is approved by:

Name and signature of psychiatrist _____ Date/Time _____

INTERPRETER'S DECLARATION

Specific Language Requirements (If Any) _____

Interpreter Services Required: Yes No

I confirm that I have accurately interpreted the contents of this form, the material risk information sheet and the related conversation/s between the patient/person giving consent and the doctor.

Interpreter's Signature _____ Date _____

FULL NAME (please print) _____