UCSF Medical Center

UCSF Benioff Children's Hospital

INFORMED CONSENT FOR ELECTROCONVULSIVE TREATMENT

VOLUNTARY OR INVOLUNTARY PATIENT
WITH VERIFIED CAPACITY TO CONSENT

UNIT NUMBER

PT. NAME

BIRTHDATE

LOCATION DATE

DO NOT SIGN THIS FORM UNTIL YOU HAVE READ IT THOROUGHLY, YOUR PHYSICIAN HAS ADEQUATELY EXPLAINED TO YOU THE MATTERS MENTIONED BELOW, AND YOU HAVE ALL THE INFORMATION THAT YOU DESIRE CONCERNING ELECTROCONVULSIVE TREATMENT.

PART 1 – CONSENT INFORMATION

The nature of electroconvulsive therapy has been fully explained to me by Dr. _____ on _____ at _____. I am satisfied with that explanation. I understand all of the following:
Date Time

1. The nature and seriousness of my mental condition.
2. The reason for using this treatment, which involves passing a controlled electrical current through my brain.
3. The electrical current produces a seizure in the brain. The amount of electricity used to produce the seizure will be adjusted to my individual needs, based on the judgment of the ECT physician. The medication used to relax my muscles will greatly soften the contractions in my body that would ordinarily accompany the seizure. I will be given oxygen to breathe. During the procedure, my heart, blood pressure, and brain waves will be monitored. Within a few minutes, the anesthetic medications will wear off and I will awaken. I will then be observed until it is time to leave the ECT area.
4. The frequency (probably _____ times per week for _____ weeks, but not to exceed _____ treatments within 30 days from the first treatment).
5. There exists a division of opinion as to the efficacy of this treatment, but it is known to include a brief episode of unconsciousness and a form of convulsion which, since the 1930's, has been known to result in a change in brain functioning, which may end or reduce depression, excitement, agitation, or disturbing thoughts.
6. The improvement associated with this treatment has sometimes been permanent and has sometimes lasted for only a few months. Without such treatment my present condition might improve or might continue with little or no change for many weeks or months, thereby endangering my health and even my life. However, there is no certainty that ECT will work for me, either partially or completely.
7. Alternatives to this treatment are no treatment, psychotherapy and medication, individually or in various combinations. These alternatives are not preferable to electroconvulsive therapy because:

   _____
8. This treatment may have the following side effects and risks:
   a. Headache, nausea, and sore muscles lasting from one hour to several weeks after treatment.
   b. Confusion lasting from an hour or so after each treatment to several weeks after a series of treatments.
   c. Memory loss lasting from an hour or so after each treatment to spotty losses lasting for several months or years after a series of treatments. Although many of these memories should return during the first few months following my ECT course, I may be left with some irreversible gaps in memory.
   d. For a short period following ECT, I may also experience difficulty in remembering new information. This difficulty in forming new memories should be temporary and typically disappears within several weeks following the ECT course.
9. There may be serious complications of heart, lung, or brain functioning as a result of the treatments or of procedures used with the treatment.
10. I have the right to accept or refuse this treatment and the right to revoke this consent for any reason at any time prior to or between treatments.
11. Special circumstances that apply to me are: (Enter "None" if there are no special circumstances):

    _____
12. Anesthesia and muscle relaxants will be used during these treatments to prevent accidental injury. Oxygen will be administered to minimize the small risk of heart, lung, brain malfunction or death as a result of the anesthesia or treatment procedures.

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PART II – CONSENT BY PATIENT

I have carefully read and understand the foregoing. I hereby consent to the performance of electroconvulsive therapy. I understand that the required 24 hours have elapsed between my signature and the time the information was provided to me.

Patient:

_____ _____
Print first name, last name Signature

Date: _____ / _____ / _____ Time: _____

Witness to Patient Signature:

_____ _____
Print first name, last name Signature

Date: _____ / _____ / _____ Time: _____

ECT Treating Physician:

_____ _____
Print first name, last name Signature

Date: _____ / _____ / _____ Time: _____

PART III – NOTIFICATION OF RELATIVE

I understand that notifying a relative of my treatment with electroconvulsive therapy is desirable, but I may invoke my right to privacy and request that no relative be notified of this treatment.

Check appropriate box:

☐ I hereby request that no relative be notified of my treatment with electroconvulsive therapy.

☐ I hereby authorize and agree that my relative, _____ , who is my

_____ be notified of my treatment with electroconvulsive therapy.
Relationship

☐ _____ was notified _____ by _____
Date Name

Patient:

_____ _____
Print first name, last name Signature

Date: _____ / _____ / _____ Time: _____

Witness to Patient Signature:

_____ _____
Print first name, last name Signature

Date: _____ / _____ / _____ Time: _____

ECT Treating Physician:

_____ _____
Print first name, last name Signature

Date: _____ / _____ / _____ Time: _____

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