UCSF Medical Center

UCSF Benioff Children's Hospital

INFORMED CONSENT REVIEW FOR ELECTROCONVULSIVE TREATMENT FOR VOLUNTARY PATIENTS

UNIT NUMBER

PT. NAME

BIRTHDATE:

DATE OF SERVICE:

I, the undersigned Consulting Physician, have reviewed the treatment record of

_____ , which included the psychiatric history,
Patient

examination, and specific statements by _____, M.D.,

indicating the reason for the choice of this treatment procedure, that all reasonable treatment modalities have been carefully considered, that convulsive treatment is definitely indicated, and that this treatment is the least drastic alternative available for this patient at this time.

Based on my personal examination of the patient, and my review of the patient's treatment record, I agree with the opinion of _____, M.D. that the patient is capable of
Attending or ECT Treating Physician

giving informed consent to the treatment.

_____ Date: _____ / _____ / _____
Consulting Physician's Signature month day year

☐ I am a board certified or board eligible psychiatrist or neurologist

_____ Date: _____ / _____ / _____
ECT Treating Physician's Signature month day year

*Voluntary patients include all patients who are not involuntarily detained, and are not under guardianship or conservatorship.

107-0004 (Rev. 06/15) WorkflowOne