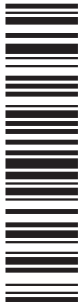
Health

Facility:

INFORMATION AND CONSENT – ELECTRO CONVULSIVE THERAPY

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _______ / _______ / _______	M.O.
ADDRESS	
LOCATION	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE



SMR025130

(Mental Health Regulation 2013, Clauses 11 and 12)
(Mental Health Act 2007 - Sections 91, 93 and 96)

INFORMATION AND CONSENT - ELECTRO CONVULSIVE THERAPY

PART 1 - INFORMATION TO CONSIDER BEFORE SIGNING

The treatment is recommended where the alternative forms of treatment have either not had the desired result or would work too slowly to be effective in a particular case.

The treatment will take the following form:

(a) You will be given a brief general anaesthetic. This involves giving a drug to relax the muscles. The anaesthetist will normally give the anaesthetic by means of intravenous injection.
(b) While you are anaesthetised, another medical practitioner will use medical apparatus designed to pass a modified electrical current for a few seconds through your brain, with the intention of affecting those parts concerned with emotion and thought.
(c) While the current is passing, the anaesthetic will prevent you from feeling anything and will also prevent your body from moving more than slightly.
(d) Treatment may be given 2 or 3 times a week.
(e) A course of treatment will generally involve up to 12 treatments but, on some occasions, more treatments will be required. Any queries you have in relation to the number of treatments you may need can be raised with your doctor.

Possible benefits of treatment:
Benefits depend upon the symptoms of the conditions for which treatment is given. Relief may be obtained from symptoms of depression, agitation and insomnia.

Possible alternative treatments:
Other treatments may also be suitable for your condition. Any queries you have in relation to these can be discussed with your doctor.

A written explanation of the alternative treatments available in relation to your condition is attached.

Possible complications of treatment:
Some patients notice a difficulty with their memory for recent events which almost invariably clears up within a month of receiving the last treatment. Some patients experience a headache or a brief period of confusion, or both, on awakening after the anaesthetic. Otherwise, because the treatment and anaesthetic are very brief and present no significant stress to the body, serious complications are uncommon. All general anaesthetics carry some risk.

Consent for treatment:
This treatment cannot be carried out without your consent (see Part 2 below), unless you are an involuntary patient at the mental health facility.

Before giving this consent you may ask your doctor any questions relating to the techniques or procedures to be followed. You may also withdraw your consent and discontinue this treatment AT ANY TIME.

Persons under 16 and involuntary patients:
If you are an involuntary patient, or if you are a person under the age of 16 years, the treatment can only be carried out after a full hearing before the Mental Health Review Tribunal.

Legal and medical advice:
You also have the right to get legal advice and medical advice before you give your consent.

Disclosure of financial relationship
Item A

To be completed by the person proposing the administration of the treatment.

(a) I declare that there is no financial relationship between me and the mental health facility or institution in which it is proposed to administer the treatment.

OR

(b) I declare that the following is a full disclosure of the financial relationship between me and the mental health facility or institution in which it is proposed to administer the treatment:

……………………………………………………………………………………………………

……………………………………………………………………………………………………

Staff Name …………………………………………… Designation ……………………………………

Signature …………………………………………… Date ……………………………………

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING

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SMR025.130

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Facility:

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GIVEN NAME	☐ MALE ☐ FEMALE
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Item B

To be completed by the medical practitioner who proposes to administer the treatment (unless that medical practitioner is also the person who completed Item A, in which case this item need not be completed).

(a) I declare that there is no financial relationship between me and the mental health facility or institution in which it is proposed to administer the treatment.

OR

(b) I declare that the following is a full disclosure of the financial relationship between me and the mental health facility or institution in which it is proposed to administer the treatment:

……

……

Staff Name …………………………………………………… Designation ……………………………………

Signature …………………………………………………… Date ……………………………………

PART 2 - CONSENT TO ELECTRO CONVULSIVE THERAPY (VOLUNTARY PATIENTS)

I, ……

(full name of patient)

consent to being treated with electro convulsive therapy.

I ACKNOWLEDGE that I have read/have had read to me Part 1 of this Form, and that I understand the information it contains.

I UNDERSTAND that I am free at any time to change my mind and withdraw from the course of treatment if I so desire.

Signature …………………………………………………… Date .... / .... /20.......

PART 3 - CONSENT TO ELECTRO CONVULSIVE THERAPY (INVOLUNTARY PATIENTS)

I, ……

(full name of patient)

consent to being treated with electro convulsive therapy.

I ACKNOWLEDGE that I have read/have had read to me Part 1 of this Form, and that I understand the information it contains.

I UNDERSTAND that I am free at any time to change my mind and withdraw from the course of treatment if I so desire.

I UNDERSTAND that my consent will be reviewed by the Mental Health Review Tribunal.

Signature …………………………………………………… Date .... / .... /20.......

CERTIFICATION OF WITNESS

I certify that all matters dealt with in this Form have been orally explained to the person in respect of whom treatment is proposed and have been so explained in a language with which that person is familiar.

Full name of witness ……………………………………………

Signature of witness …………………………………………… Date .... / .... /20.......

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING

SMR025130