

ECT CONSENT FORM - PART A (for Consultant use)

SERVICE USER DETAILS

SURNAME/FAMILY NAME:

FIRST NAMES

DATE OF BIRTH MALE or FEMALE
Select / Write "M" or "F"

CONSULTANT PSYCHIATRIST

NHS No MPI No

SPECIAL REQUIREMENTS
(eg: other language, other communication methods etc..)

PLEASE NOTE

- Under no circumstances must the Service User be coerced into ECT, eg: implying the MHA will be applied if the Service User refuses consent.
- Should the Service User's Capacity to Consent to ECT be in doubt, the Trust "Capacity Assessment Form" should be completed and attached to this Consent Form.
- Clinicians must comply with the MHA 1983 Code of Practice (revised 2008) relating to ECT. The relevant documentation must be completed and attached to this Consent Form.
- Should the Service User be detained under the Mental Health Act (MHA), the consent still needs to be completed and the Mental Health Act Commission Leaflet 3 should be given to the Service User
- Should the Service User be under 18 years old the Prescribing Consultant must adhere to MHA Code of Practice 2008.

TO BE RETAINED IN SERVICE USER'S NOTES

SU's NAME _____ NHS No _____

1) STATEMENT BY PRESCRIBING PSYCHIATRIST OR NOMINATED PSYCHIATRIST

EITHER: A course of Unilateral Electro Convulsive Therapy up to a maximum of _____ treatments

OR: A course of Bilateral Electro Convulsive Therapy up to a maximum of _____ treatments

I have explained: Nature of treatment
Description of the process
This procedure will involve both: (Write "X")
General Anaesthesia Muscle Relaxation

I have also explained: The likely benefits
Likelihood of success

I have pointed out: The risks of adverse effects
Likelihood of adverse effects (including Dental Damage)
Possibility of memory loss(occasionally permanent)
Transient side effects, eg: Post-treatment confusion

I have discussed: The likely consequences of not having ECT
Treatment alternatives
Alternative treatments will be available if patient decides not to have ECT

I have asked the Service User: if there are any further questions
about any other particular concerns

The "ECT Information Booklet" and a copy of this Consent Form has been provided (including those who are unable to consent). Include what additional (verbal and/or written) information was discussed at the Service User's request:

SIGNED: _____

PRINT NAME: _____

DESIGNATION: _____ **DATE:**

CONTACT DETAILS: (telephone No)
(if Service User wants to discuss options later)

2) STATEMENT OF INTERPRETER (where appropriate)

I have interpreted the information above to the Service User to the best of my ability and in a way in which I believe he/she can understand.

SIGNED: _____

PRINT NAME: _____

DATE:

SU's NAME _____ NHS No _____

3) STATEMENT OF SERVICE USER

Please read this form carefully. You should already have your own copy of page 2, and an ECT Information Booklet that describes the intended benefits and frequently occurring risks of ECT. If not, you will be offered a copy now. If you have any further questions, do ask - we are here to help you. Should you wish to obtain additional information or access to independent advocacy, please let us know.

You have the right to change your mind **at any time**, including **after you have signed this form**.

I agree to the procedure and course of treatment described on this form.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

I understand that I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of my situation prevents this.

I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

I have been told about additional procedures which may become necessary during my treatment. I have listed below any procedures **which I do not wish to be carried out** without further discussion:

I understand that I have 24 hours to think about the ECT information provided. I can use this time to discuss the ECT with my relatives, friends and/or advisers. Only after this will I make a final decision about consenting for the treatment.

I have had the opportunity to discuss the following concerns about ECT with the Doctor:

SERVICE USER'S SIGNATURE _____

PRINTED NAME: _____

DATE:

4) A witness should sign below if the Service User is unable to sign but has indicated his or her consent.

SIGNED: _____

PRINT NAME: _____

DESIGNATION: _____

DATE:

IMPORTANT NOTES: *(Select / or write "X" if applicable)*

See Advanced Directive / Living Will *(eg: Jehovah's Witness form)*

Service User's relatives have been informed about the treatment. This does not conflict with issues relating to Service User confidentiality. Please document discussions in Service User's

Issues relating to Service User Confidentiality. Please document discussions in Service User's Notes.

THESE FORMS MUST BE ACCOMPANIED BY T4 / T6 / S.62 COPY OF SECTION PAPERS