



0100000

PLACE LABEL HERE.

IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

CONSENT FOR MAINTENANCE ELECTROCONVULSIVE THERAPY (ECT) AND ADMINISTRATION OF ANESTHESIA

Date Consent Obtained: _____

A. INFORMATION ABOUT MAINTENANCE OR CONTINUATION ELECTROCONVULSIVE THERAPY, RISKS, AND ALTERNATIVES

1. I have received information about my condition, the proposed treatment with continuation/maintenance Electroconvulsive Therapy, alternative treatments, and related risks. This form contains a brief summary of that information. I have received all the information I wish and satisfactory explanation of any unfamiliar terms used. I understand I may refuse consent and I GIVE MY INFORMED AND VOLUNTARY CONSENT to the proposed procedures and the other matters shown below.

2. I HEREBY AUTHORIZE Dr. Cohen and/or an attending physician or physician in training (resident) as he may select to treat my condition (including further diagnosis).

3. I understand my condition to be (check one):
 - Major Depressive Disorder
 - Bipolar Disorder
 - Schizophrenia
 - Other (Specify: _____)

4. I understand the proposed procedure to be Electroconvulsive Therapy and have discussed the following information about ECT:

I will receive ECT to prevent return of my illness. Whether ECT or an alternative treatment, like medication or psychotherapy, is most appropriate for me at this time depends on my prior experience with these treatments in preventing the return of symptoms, the features of my illness, and other considerations. Why continuation/maintenance ECT has been recommended for me has been explained.

Continuation /maintenance ECT involves a series of treatments with each usually separated in time by 1 or more weeks. Continuation/ maintenance ECT is usually given for a period of several months or longer. These treatments may be given on an inpatient or outpatient basis.

To receive each continuation /maintenance treatment I will come to a specially equipped area in this facility. The treatments are usually given in the morning. Because the treatments involve general anesthesia, I will have had nothing to eat or drink after midnight before each treatment. Before the treatment, a small needle will be placed in my vein so that I can be given medications. An anesthetic medication will be injected that will quickly put me to sleep, I will then be given another medication that will relax my muscles. Because I will be asleep, should not experience pain or discomfort or remember the procedure. Other medications may also be given depending on my needs.

To prepare for the treatment, monitoring sensors will be placed on my head and body. Blood pressure cuffs will be placed on an arm and leg. This monitoring involves no pain or discomfort. After I am asleep, a carefully controlled amount of electricity will be passed between two electrodes that have been placed on my head.

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I may receive bilateral ECT or unilateral ECT. In bilateral ECT, one electrode is placed on the left side of the head, the other on the right side. In unilateral ECT, both electrodes are placed on the same side of the head, usually the right side. Right unilateral ECT (electrodes on the right side) may produce less memory difficulty than bilateral ECT. However, for some patients bilateral ECT may provide a more effective treatment and may not require as high a dosage of energy. My doctor will carefully consider the choice of unilateral or bilateral ECT.

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 from a mask to breathe. The seizure will last for approximately 1 minute. 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 monitored in a recovery area until medically cleared by the anesthesiologist to leave the ECT clinic.

The number of continuation/maintenance treatments that I will receive will depend on my clinical course. Continuation ECT is usually given for at least 6 months. If it is felt that continuation ECT is helpful and should be used for a longer period (maintenance ECT), I will be asked to consent to the procedure again.

ECT is expected to prevent the return of my psychiatric condition. Although for most patients ECT is effective in this way, I understand that this cannot be guaranteed. With continuation/maintenance ECT I may remain considerably improved or I may have a partial or complete return of psychiatric symptoms.

5. I understand the RISKS associated with the proposed procedures to be as follows:

Like other medical treatments, ECT has risks and side effects. To reduce the risk of complications, I will receive a medical evaluation before starting ECT. The medications I have been taking may be adjusted. However, in spite of precautions, it is possible that I will experience medical complication. As with any procedure involving general anesthesia there is a remote possibility of death from ECT. The risk of death from ECT is very low, about one in 10,000 patients. This rate may be higher in patients with severe medical conditions.

In rare instances, ECT can result in serious medical complications, such as heart attack, stroke, respiratory difficulty, or continuous seizure. More often, ECT results in irregularities in heart rate and rhythm. These irregularities are usually mild and short lasting, but in rare instances can be life-threatening. With modern ECT technique, dental complications are infrequent and bone fractures or dislocations are very rare.

If serious side effects occur, I understand that medical care and treatment will be instituted immediately and that facilities to handle emergencies are available. I understand, however, that neither the institution nor the treating physicians are required to cover the costs of long-term medical treatment should that be necessary. I shall be responsible for the cost of such treatment, whether personally or through medical insurance or other medical coverage. I understand that no compensation will be paid for lost wages or other consequential damages.

The minor side effects that more frequently occur include headache, muscle soreness, and nausea. These side effects usually respond to simple treatment.

When I awaken after each treatment, I may be confused. This confusion usually goes away within 1 hour.

Memory loss is a common side effect of ECT. The memory loss with ECT has a characteristic pattern, including problems remembering past events and new information. The degree of memory problems is often related to the number and type of treatments given. A smaller number of treatments is likely to produce less memory difficulty than a larger number. Shortly following a treatment, the problems with memory are greatest. As time from treatment increases, memory improves.

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I may experience difficulties remembering events that happened before and while I received ECT. The spottiness in my memory for past events may extend back to several months before I received ECT, and, less commonly, for longer periods of time, sometimes several years or more. Although many of these memories should return during the first few months following continuation/maintenance ECT, I may be left with some permanent gaps in memory.

For a short period following each treatment, I may also experience difficulty in remembering new information. This difficulty in forming new memories should be temporary and will most likely disappear following completion of continuation/maintenance ECT.

The effects of continuation /maintenance ECT on memory are likely to be less pronounced than those during an acute ECT course. By spreading treatments out in time, with an interval of a week or more between treatments, there should be substantial recovery of memory between each treatment.

Because of the possible problems with confusion and memory, it is important that I not drive or make any important personal or business decisions the day that I receive a continuation /maintenance treatment. Limitations on my activities may be longer depending on the side effects I experience following each treatment and will be discussed with my doctor.

I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the risks of the procedure.

- 6.** I understand the ALTERNATIVES TO ECT and the related risks to be medication, psychotherapy, or no treatment.

Whether ECT or one of these alternative treatments is most appropriate for me depends on my prior experience with these treatments, the features of my illness, and other considerations. Why ECT has been recommended for me has been explained to me.

- 7.** I consent to the administration of such anesthetics as may be considered necessary or advisable by the anesthesiologist in charge of my care. I acknowledge that I have been informed of the nature of the anesthetic procedure and I understand that the anesthesia may actually be administered by a physician in training (resident) or nurse anesthetist with, or under the direction of, the anesthesiologist.

- 8.** The conduct of ECT at this facility is under the direction of Bruce J. Cohen, M.D. I understand that I can contact him at (434) 924-2241 if I have further questions after talking with my treating doctors. I understand that I am free to ask my doctor or members of the ECT treatment team questions about ECT at this time or at any time during or after the ECT course. My decision to agree to ECT is a voluntary one, and I understand that I can withdraw my consent for further treatment at any time.

- 9.** I also have been given the opportunity to watch an educational videotape about ECT.

(Please initial one of the following statements):

_____ I have viewed the educational videotape

_____ I have not yet viewed the videotape, but plan to view it on _____

_____ I would prefer not to view the videotape

- 10.** I have been given a copy of this consent form to keep.

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B. PATIENT OR LEGAL REPRESENTATIVE SIGNATURE:

By signing below I state that I am 18 years of age or older, or otherwise authorized to consent. I have read or have had explained to me the contents of this form. I have had a chance to ask questions and all of my questions have been answered.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE

PRINTED NAME

DATE/TIME

IF SIGNED BY PERSON OTHER THAN THE ADULT PATIENT, CHECK RELATIONSHIP TO PATIENT:		
<input type="checkbox"/> 1. Guardian	<input type="checkbox"/> 4. Adult Child	<input type="checkbox"/> 6. Adult Brother/Sister
<input type="checkbox"/> 2. Agent Named in Advance Directive	<input type="checkbox"/> 5. Parent	<input type="checkbox"/> 7. Other Blood Relative
<input type="checkbox"/> 3. Husband/Wife		
FOR MINOR PATIENTS:		
<input type="checkbox"/> 1. Parents	<input type="checkbox"/> 2. Guardian or Legal Custodian	<input type="checkbox"/> 3. Authorized person for child in out-of-home placement

C. PHYSICIAN STATEMENT/SIGNATURE:

I have explained the procedure(s) stated on this form, including the possible risks, complications, alternative treatments (including non-treatment) and anticipated results to the patient and/or his/her representative. The patient and/or their representative has communicated to me that they understand the contents of this form.

SIGNATURE OF PHYSICIAN OR DESIGNEE OBTAINING CONSENT

PRINTED NAME

DATE/TIME

D. WITNESS SIGNATURE:

SIGNATURE OF WITNESS

PRINTED NAME

DATE/TIME

E. INTERPRETER ATTESTATION (when applicable)

Interpretation has been provided by

SIGNATURE OF INTERPRETER/CYRACOM ID#

DATE/TIME