



1200000

PLACE LABEL HERE.

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

ELECTROCONVULSIVE THERAPY (ECT) PATIENT MEDICATION LIST

Allergies: _____ Latex: Yes No

Instructions: List all medicines including prescription, over-the-counter, herbals, vitamins and dietary supplements you are currently taking.

	MEDICINE NAME / STRENGTH Example: Sencidem 40 mg	HOW MUCH / WHEN I TAKE IT Example: 2 tablets twice a day with meals	WHAT I TAKE IT FOR Example: Blood Pressure	OTHER INFORMATION Example: Get bloodwork monthly	COMMENTS
1					
2					
3					
4					
5					
6					
7					
8					

The information I have provided is correct to my knowledge.

Name: _____ Relationship: Patient Parent/Guardian Other: _____

Please note:

- Completion of this procedure does not have any affect on your medications.
- If any change is made by the doctor, it will be noted below and you will be given a copy of this list, along with discharge instructions.
- If you have questions about your medications please call your doctor.

If patient unable to write a list:

Reviewed Medication List provided from _____ Attached

The above information has been review in accordance with the protocol for the patient's exam:

Technologist/Nurse Name/Signature _____ Date: _____

CHANGES TO THE PATIENT MEDICATION LIST:

	MEDICINE NAME / STRENGTH Example: Sencidem 40 mg	HOW MUCH / WHEN I TAKE IT Example: 2 tablets twice a day with meals	WHAT I TAKE IT FOR Example: Blood Pressure	OTHER INFORMATION Example: Get bloodwork monthly
1				
2				
3				

MD MEDICATIONS REVIEWED – INITIAL EACH VISIT

MD Name / PIC /		Visit 1	Visit 2	Visit 3	Visit 4	Visit 5	Visit 6	Visit 7	Visit 8	Visit 9	Visit 10
	Date										
	Initials										

Copy provided to patient by: _____

NAME/SIGNATURE

DATE