Santé
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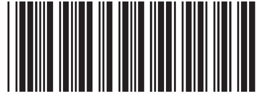
Québec



DT9281

ELECTROCONVULSIVE THERAPY AND ANESTHESIA CONSENT FORM

I have been informed of the content of the brochure about electroconvulsive therapy (ECT).
(What you need to know about ECT, Centre of Excellence in electroconvulsive Quebec (CEECTQ)) ________ Initials

I acknowledge that I (or the person I represent) have (has) been prescribed ECT to treat: ____________________ Enter the name of the illness ________ Initials

1. Information about ECT

My physician, ______________________________ , explained the information in the brochure to me and answered all my questions satisfactorily. He also told me his reasons for choosing ECT for my mental condition, and described the benefits, risks and side effects of ECT, the consequences of refusing treatment and the scientifically recognized alternatives to this treatment.

I had time to discuss the appropriateness of using this treatment and its alternatives with my family and the health care team.

I understand that ECT involves delivering, **under general anesthesia**, electrical current into the skull through electrodes to induce a seizure. I can receive bifrontal, bitemporal or unilateral ECT, depending on the severity of the illness, the potential adverse effects and my response to the treatment. Although most people respond quickly to ECT, others see their condition improve and then relapse again, requiring additional sessions, and still others see no improvement. The seriousness of the side effects can also vary from one person to another.

I was informed that my general medical condition will be closely monitored by the medical team; members of the team will measure my brain's electrical activity, my blood pressure, my pulse and my blood oxygen level.

I was informed that this therapy is generally indicated for the illnesses below:
- Major refractory depression
- Some forms of catatonia
- Refractory bipolar mania
- Refractory schizophrenia

I was informed about ECT is indicated when:
- Conventional therapies have failed
- Conventional therapies are not tolerated or are contraindicated
- The user's life is threatened in the short term
- ECT is effective in treating the user's condition
- The user has responded well to ECT in the past and he prefers this treatment

I was informed of the most common side effects associated with ECT are:
- Confusion
- Headaches
- Body aches or muscle stiffness
- Nausea
- Memory problems (usually related to the number and type of treatment).
  These side effects usually disappear within days or months of ECT treatment. However, certain memories may be permanently lost.

I was informed of the following rare complications:
- Dislocation or fracture of any bone
- Dental complications
- Irregular heartbeat
- Death (ECT mortality rates are equivalent to those for general anesthesia)

User's name	File No.

I have read the information above and understand that
I can receive answers to my questions from the medical staff. ______ Initials

2. Consent for ECT treatments

I understand that this consent is voluntary and can be withdrawn verbally at any time.

I consent to receive ECT treatment at the health care facility ____________________
as follows:

Acute phase: from ______ to ______ ECT sessions for a period of up to two (2) months, at a frequency of two (2) to three (3) sessions per week.

Maintenance phase: from ______ to ______ ECT sessions for a period of up to six (6) months, at a frequency that will be defined by the physician based on my progress.

I agree to receive the necessary emergency care if my condition worsens during treatment.

Signatory: user or authorized person	Date (month, day, year)	Signature of witness (optional)
		Family or friend or facilitator
Countersignatory: attending physician	Date (month, day, year)	

3. Pledge of the individual

In preparation for the ECT, I pledge:

- I will not drink water or any other liquid at least eight (8) hours before each ECT session
- I will not consume any food at least eight (8) hours before each session of ECT
- I will take only the drug(s) authorized by the physician before each ECT session
- I will be accompanied by someone after each ECT session

I agree to comply with any other instructions from the institution administering the ECT throughout my ECT treatment and recovery. ______ Initials

4. Consent for anesthesia

I consent to the administration of general anesthesia by ____________________
or another licensed physician during my ECT treatment.

I acknowledge that I have been informed of the type, risks and effects of the anesthesia.

Signatory: user or authorized person	Date (month, day, year)	Signature of witness (optional)
		Family or friend or facilitator
Countersignatory: attending physician	Date (month, day, year)	

5. Pledge of the attending physician

- ☐ I will confirm the ability of the user to consent to the proposed treatment.
- ☐ I will use the consent of the user's authorized representative.

I explained to the user (or his representative) the relevant facts about ECT (nature, purpose, benefits, risks, side effects, alternative treatments and procedures) presented in the brochure and essential for informed consent.

I agree to answer questions and keep the user informed of his progress and the side effects throughout his ECT treatment.

I understand that consent must be obtained again in the event of a change in treatment (during the acute or maintenance phase)

Name of attending physician	Signature of attending physician	Date (month, day, year)