AU Medical Center
INFORMED CONSENT FOR ECT

DOB: EMRN:

ACCT #:

LOCATION:

* - - *

Date: ____/____/____ Time: _____
MM DD YY (Military Time)

1. I, _____, understand and acknowledge that I am to undergo
[Printed Name of Patient or Guardian]

the following procedure(s): **Electroconvulsive Therapy (ECT)** ***under general anesthesia***

Estimated number of treatments**: _____**

2. This procedure is to be performed **by or under the direction of Peter Rosenquist, MD.**

I further understand that my physician may be assisted during this procedure by other physicians or practitioners whom he designates; and who may assist or perform portions of the procedure(s) at the request or under the direction of my physician.

3. I understand that the purpose of this procedure is **to improve symptoms of mental illness.**

4. I understand that this procedure involves certain risks. **These may include: Headache, jaw pain, muscle soreness, difficulties in attention and concentration, memory loss, heart arrhythmias. Risk of death is very low, about 1 in 10,000 patients.** ***General anesthesia is associated with some common minor side effects such as a sore throat, post-operative nausea and vomiting, dry mouth, shivering, sleepiness or mild hoarseness, as well as some very rare serious complications such as heart attack, stroke and death. Risks and complications associated with airway management under general anesthesia include dental injury, minor trauma to the lips, tongue and other upper airway soft tissue structures.***

5. I acknowledge and understand that during the course of the procedure(s) described above, it may become appropriate to perform additional procedures which are unforeseen or not known to be needed at the time this consent is given. Therefore, I hereby consent to and authorize AU Medical Center (AUMC), its medical staff and those other medical personnel selected by AUMC to make decisions concerning the performance of such procedure(s) as they deem reasonably appropriate in the exercise of their professional judgment. This consent shall also extend to the treatment of all conditions which may arise during the course of such procedures including those conditions which may be unknown or unforeseen at the time this consent is given. If conditions permit, an attempt to notify an authorized family member of changes occurring in the operating room will be made.

6. I understand that if I do not undergo this proposed procedure(s), my prognosis is: **Uncertain.**

7. I understand that the practical alternatives to this procedure include: **Medications.**

8. I also consent to diagnostic studies, tests, anesthesia, x-ray examinations and any other treatment or courses of treatment relating to the diagnosis or procedures described herein. A separate informed consent document may be required prior to some of these procedures.

9. I understand that AUMC is an academic medical center with education as an integral part of its mission. Consequently, I authorize the presence of students and other observers for educational purposes during my procedure.

10. I understand that I have the right to ask questions and I hereby certify that I have been given the opportunity to ask questions and that any such questions have been answered or explained to my satisfaction.

11. I understand that no guarantees, assurances, or promises have been made to me concerning the results of this procedure.

12. By signing this form, I acknowledge that I have read it carefully or had it read or explained to me and that I understand this form and its contents, and I hereby voluntarily consent to and request AUMC, its medical staff, and all other medical personnel which may otherwise be involved in my treatment to perform the procedure(s) described or otherwise referred to herein.

(This consent will be valid for six months from date of signature unless revoked.)

Patient / Guardian [Printed Name]:_____

_____ **Date:** ____/____/____ **Time:** _____
Patient / Guardian [Signature] MM DD YY (Military Time)

Witness [Printed Name]: _____

_____ **Date**: ____/____/____ **Time:** _____
Witness [Signature] MM DD YY (Military Time)

I, _____, certify that I explained the above referenced procedure(s) to
[Printed Name of Practitioner]
_____, on _____/_____/_____.
[Printed Name of Patient/Guardian] **MM DD YY**

I further certify that the patient was given an opportunity to ask questions regarding the procedure(s), potential risks, and possible alternatives.

_____ **Date:** ____/____/____ **Time:** _____
[Physician Signature] MM DD YY (Military Time)

TELEPHONE CONSENT When a telephone consent is being obtained, the above information must be read to the person consenting.

I, _____, read the above information to _____ at _____ Date: ____/___/___.
(Name of Practitioner) (Name of Person Consenting) (Military Time) MM DD YY

_____states that he/she is _____ of _____ and he/she
(Name of Person Consenting) (Relationship to Patient) (Name of Patient)

authorized the treatment/procedure described above and has been provided an opportunity to ask any desired questions.

_____ Date: ____/____/____ Time: _____
Practitioner's Signature/ Title MM DD YY (Military Time)

I witnessed and overheard the telephone conversation in which the above consent was given to perform the desired treatment/procedure.

_____ _____
Signature of First Witness Signature of Second Witness

_____ _____
Address of First Witness Address of Second Witness