Disclosure and Consent for Electroconvulsive Therapy

Exhibit A

To the patient (and the guardian of the person of the patient who has been adjudicated incompetent to manage his or her own personal affairs): You have the right to be informed about your condition and the proposed treatment so that you can make the decision whether or not to undergo the procedure after knowing the general risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed to give or withhold your consent to the procedure.

Do not sign this form until you have all the information you desire concerning electroconvulsive therapy (ECT). No person under the age of 16 shall be administered ECT.

I voluntarily request Dr. _____, as my physician, and such associates, technical assistants, and other health care providers as they may deem necessary to treat my condition with electroconvulsive therapy (ECT). I understand the nature and seriousness of my mental condition, which has been explained to me by my physician as follows: _____

_____.

I understand that electroconvulsive therapy with modification by anesthesia and muscle relaxants is planned for me. I understand that ECT involves passage of an electrical stimulus across my brain for up to a few seconds, sufficient to induce a seizure. In my case, the treatments will probably be given _____ times per week for _____ weeks, not to exceed a total of _____ treatments **OR** for maintenance therapy, _____ times per month for _____ months.

I understand that my doctor believes that the benefits of ECT for me outweigh the risks. My doctor and I have considered and discussed alternative treatments (for example, psychotherapy and/or medication). Other treatments are not presently recommended as a substitute for ECT by my doctor because _____

_____.

If any aspect of my treatment is experimental, it is explained here:_____

_____

_____

I voluntarily consent and authorize the experimental aspects of treatment.

I understand that ECT is generally accepted by the psychiatric profession. The Food and Drug Administration presently regards ECT devices as reasonably safe and effective when used to treat severe depression, but the safety and effectiveness of these devices has not been determined for any other use. There is a division of opinion as to the effectiveness of this treatment.

I also understand that this treatment may have brief side effects: headaches, muscle soreness, and confusion. I understand that ECT may eliminate or reduce the symptoms of my disorder, such as (but not necessarily limited to) depression, agitation, and disturbing thoughts. In my case, there may be temporary improvement, permanent improvement, or no improvement.

Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to electroconvulsive therapy. I realize that common to all surgical, medical, and/or diagnostic procedures is the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reactions, and even death. I also realize that the following risks and hazards may occur in connection with electroconvulsive therapy, and their probability, degree, and duration have been explained to me:

1. Memory changes of events prior to, during, and immediately following the treatment.
2. Fractures or dislocation of bones.
3. Significant temporary confusion requiring special care.
4. The possibility of permanent memory dysfunction, including permanent, irrevocable memory loss.
5. The remote possibility of seizures.
6. The possibility of death.

I (do) (do not) consent to use of blood and blood products as deemed necessary to sustain my life in an emergency.

I understand that my physician may discover other or different conditions which require additional or different procedures than those planned. I authorize my physician, and such associates, technical assistants, and other health care providers to perform such other procedures which are advisable in their professional judgment to sustain my life in an emergency.

I understand that no warranty or guarantee has been made to me as to result or cure.

Anesthesia and muscle relaxants will be used during these treatments to prevent accidental injury. I understand that anesthesia involves risks and hazards, but I request the use of anesthesia for the relief and protection from pain and accidental injury during the procedure. I realize the anesthesia may have to be changed possibly without explanation to me.

Supplemental information specific to the patient: My physician's assessment of the presence or absence of indications and contraindications to ECT, based on the results of the medical evaluation and consultations, if any, conducted prior to treatment, is described in the Supplemental Statement (Exhibit B).

I understand that certain complications may result from the use of anesthesia including respiratory problems, drug reactions, paralysis, brain damage, or even death. Other risks and hazards which may result from the use of general anesthetics range from minor discomfort to injury to vocal cords, teeth, or eyes. Oxygen will be administered to minimize the small risk of heart, lung, brain malfunction or death as a result of the anesthesia or treatment procedures. I understand that other risks and hazards resulting from spinal or epidural anesthetics include headache and chronic pain.

I certify that this form and the written supplement have been fully explained to me, that I have read it or had it read to me, that the blank spaces have been filled in, and that I understand its contents. I have been given the opportunity to ask questions about my condition, alternative forms of anesthesia and treatment, risks of nontreatment, the procedures to be used, and the risks and hazards involved, and I believe that I have sufficient information to give this informed consent. If I am the guardian of the person of a patient who has been adjudicated incompetent to manage his or her own personal affairs, I certify that my decision to give or withhold informed consent is based on knowledge of what the patient would desire, to the extent that I am aware.

I have the right to accept or refuse this treatment. If I consent, I have the right to revoke my consent for any reason at any time prior to or between treatments without affecting the quality of care I receive.

I understand that my consent is for one individual treatment, and that additional treatments require additional written informed consent, which must also be evidenced by signature on this form.

As evidenced by my signature below or on the following page, I consent to ECT and related anesthesia for the date indicated in the left hand column "Date of Treatment."

Date of Treatment	Person Giving Consent		Witness	
	Signature and Printed Name	Date	Signature, Printed Name, Address	Date

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