

Supplemental Statement

Patient name: _____ Date _____

signature of physician completing form printed name of physician completing form

1. **Indications for ECT in this patient:** _____

2. **Medical evaluation results:** A thorough evaluation of the patient's physical and psychiatric status, with review of pertinent laboratory and other findings, was conducted within 30 days prior to initiation of this course of ECT. The results, which are recorded in the patient's permanent medical record, indicate the following notable findings: _____

3. **Contraindications to ECT:** The following significant contraindications are based upon this patient's medical history, physical and neurological examination, laboratory findings, electrocardiogram, and X-rays, as appropriate. _____

4. **Results of consultation(s) (psychiatric and other medical) obtained, as relevant to ECT:**

For a patient 65 years of age or older:	
5. Current medical condition(s): The following current medical condition(s) of this patient may increase the possibility of injury or death as a result of ECT. _____ _____	
6. Based on the findings and consultations described above, I have determined that ECT is medically necessary for this patient as evidenced by my signature below.	
_____ signature of treating physician	_____ date
_____ signature of consulting physician	_____ date