# Section 66

|  | ***Complete person details or affix patient label in box below:*** |
| --- | --- |
| **Full name of person:** |  |       |  |
| **Also known as** |  |       |  |
| **Date of Birth:** |  |    / /   |  |
| **HRN:** |  |       |  |
| **Sex:** |  | [ ]  Male [ ]  Female [ ]  Non-binary [ ]  Not specified |
|  |  | **Patient Label** |
|  |
| Informed consent of patient |
| The doctor below has explained my diagnosis for which Electroconvulsive therapy (ECT) is proposed. |
|      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Full name of doctor performing ECT** |
|[ ]  The doctor has also explained ECT, how it is done and how it will benefit my condition. |
|[ ]  I understand that ECT is given under a general anaesthetic and with a muscle relaxant. The doctor has explained their purpose and how they are given. |
|[ ]  The doctor has explained the risks and possible side effects of ECT, the general anaesthetic and the muscle relaxant. |
|[ ]  The doctor has explained other possible treatment options for my condition, including the advantages, disadvantages and risks of each option and the risks if I do not have treatment. |
|[ ]  I have been given the statement of rights Electroconvulsive treatment and the information has been explained to me. |
|[ ]  I have had an opportunity to ask questions about ECT and other treatment options and my questions have been answered. |
|[ ]  I understand the information I have been given. |
|[ ]  I have had an opportunity to get other advice or help to make the decision. |
|[ ]  I understand that the results of ECT cannot be guaranteed. If changes to my ECT treatment are needed that affect my consent, these will be discussed with me and a doctor will seek my informed consent to the changes. |
|[ ]  I have had enough time to make my decision. |
|[ ]  I understand that I can withdraw my consent to ECT at any time, even after the course of ECT has started. |
| As such, I consent to a course of ECT up to 12 treatments, which may take up to       weeks to complete *(up to a maximum of 26 weeks)*.I am 18 years or older: Yes [ ]  No [ ]  |
| Diagnosis:       |
| Signature of patient:       | Date:    / /   |
| Signature of witness:       | Date:    / /   |
|  |
| **Form Requirements**[ ]  Placed on clinical file |