PLEASE ATTACH PATIENT LABEL OR PROVIDE:

NAME ______________________________

MRN ______________ FIN ________________

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.

Disclosure and Consent for Electroconvulsive Therapy
Exhibit A

PLEASE ATTACH PATIENT LABEL OR PROVIDE:

NAME ______________________

MRN ____________ FIN ____________

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.

PLEASE ATTACH PATIENT LABEL OR PROVIDE:

NAME ____________________

MRN __________ FIN __________

Disclosure and Consent for Electroconvulsive Therapy

Exhibit A

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 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.

☐ UMC: 602 Indiana Avenue; Lubbock, TX 79415 ☐ TTUHSC: 3601 4th Street; Lubbock, TX 79415
☐ UMC Health & Wellness: 11011 Slide Road; Lubbock TX 79424

Interpretation/ODI (On Demand Interpreting) ☐ Yes ☐ No ____________________
Date/Time (if used)

Alternative forms of communication used ☐ Yes ☐ No ____________________
Printed name of interpreter

PLEASE ATTACH PATIENT LABEL OR PROVIDE:

NAME ____________________

MRN ____________ FIN ____________

Disclosure and Consent for Electroconvulsive Therapy

Exhibit A

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/Time	Signature and Printed Name	Date/Time

Disclosure and Consent for Electroconvulsive Therapy

Exhibit A

Signatures (continued)

Date of Treatment	Person Giving Consent		Witness	
	Signature and Printed Name	Date/Time	Signature and Printed Name	Date/Time

Disclosure and Consent for Electroconvulsive Therapy

PLEASE ATTACH PATIENT LABEL OR PROVIDE:

NAME ______________________

MRN ____________ FIN ____________

Electroconvulsive Therapy Consultation Report Supplemental Statement (Exhibit B)

Date: ______________

______________________________ ____________ ____________

Signature of Physician completing form Date Time

____

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 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 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 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: ______________________________

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 Time

______________________________ ____________ ____________

Signature of Consulting Physician Date Time

PLEASE ATTACH PATIENT LABEL OR PROVIDE:

NAME ____________________________________

MRN __________________FIN ____________________

Disclosure and Consent for Electroconvulsive Therapy

TO THE PATIENT: You have the right to be informed about 1) your condition, 2) the recommended medical care or surgical procedure, and 3) the risks related to this care/procedure. This disclosure is designed to provide you this information so that you can decide whether to consent to receive this care/procedure. Please ask your physician /health care provider any remaining questions you have before signing this form.

Description of Medical Care and Surgical Procedure(s):
I voluntarily request my physician/health care provider (name/credentials): ______________________________
and other health care providers, to treat my condition which is: ____
____

I understand that the following care/procedures are planned for me: **Electroconvulsive Therapy (ECT)**

I (we) understand that if residents and/or fellow (physicians in advanced training) perform important tasks related to the procedure(s) listed above, they will do so in accordance with UMC Health System policy, based on their skill set and under the supervision of my physician.

I (we) understand that qualified medical practitioners who are not physicians may be involved in the administration of anesthesia. These qualified medical practitioners will provide service only within their scope of practice, as determined under Texas law and UMC Health System policy.

Potential for Additional Necessary Care/Procedure(s):
I understand that during my care/procedure(s) my physician/health care provider may discover other conditions which require additional or different care/procedures(s) than originally planned.

I authorize my physicians/health care providers to use their professional judgement to perform the additional or different care/procedure(s) they believe are needed.

Use of Blood:
I consent to the use of blood and blood products as necessary for my health during the care/procedure(s). The risks that may occur with the use of blood and blood products are:

1. Serious infection including but not limited to Hepatitis and HIV which can lead to organ damage and permanent impairment.
2. Transfusion related injury resulting in impairment of lungs, heart, liver, kidneys and immune system.
3. Severe allergic reaction, potentially fatal.

Please Initial “YES” or “NO” _________YES _________NO

Risks Related to this Care/Procedure(s):
Just as there may be risks and hazards to my health without treatment, there are also risks and hazards related to the care/procedure(s) planned for me.

I understand that all care/procedures(s) involve some risks, ranging from minor to severe. These risks include infection, blood clots in veins, lungs or other organs, hemorrhage (severe bleeding), allergic reactions, poor wound healing, and death.

The chances of these occurring may be different for each patient based on the care/procedure(s) and the patient’s current health

PLEASE ATTACH PATIENT LABEL OR PROVIDE:
NAME ____________________
MRN __________ FIN __________

Disclosure and Consent for Electroconvulsive Therapy

Risks of this care/procedure(s) include, but are not limited to
(See List A – A.1. General and List A – Q. Psychiatric Procedures).

LIST A (SECTION 601.1)
Procedures Requiring Full Disclosure. The following treatments and procedures require full disclosure by the physician or healthcare provider to the patient or person authorized to consent for the patient.

A. ANESTHESIA.
1. General.
   a. Permanent organ damage.
   b. Memory dysfunction/memory loss.

Q. PSYCHIATRIC PROCEDURES
Electroconvulsive therapy with modification by intravenous muscle relaxants and sedatives.
   a. Memory changes of events prior to, during and immediately following the treatment.
   b. Fractures or dislocations of bones.
   c. Significant temporary confusion requiring special care.
2. Other procedures. No other procedures assigned at this time.

Granting of Consent for this Care/Procedure(s)
In signing below, I consent to the care/procedure(s) described above. I acknowledge the following:

- I understand this care/procedure(s) does not guarantee a result or a cure to my condition.
- I have been given an opportunity to ask questions I may have about:
  1. Alternative forms of treatment,
  2. Risks of non-treatment,
  3. Steps that **will** occur during my care/procedure(s), and
  4. Risks and hazards involved in the care/procedure(s).
- I believe I have enough information to give this informed consent.
- I certify this form has been fully explained to me and the blank spaces have been filled in.
- I have read this form or had it read to me.
- I understand the information on this form.

If any of those statements are not true for you, please talk to your physician/health care provider before continuing.

I (we) hereby authorize the release of my social security number to the manufacturer of a tracked medical device I may receive, in accordance with federal laws and regulations. I further understand that my social security number may be used by the manufacturer to help locate me, if there is a need regarding this medical device. I release the hospital from any liability that might result from releasing this information.

PATIENT/OTHER LEGALLY RESPONSIBLE PERSON (signature required):

____________________	__________	__________AM/PM
Signature of Patient/Other Legally Responsible Person	Date	Time

____
Printed Name of Person Signing

____________________	__________	__________AM/PM
Witness Signature	Date	Time

____
Printed Name of Witness Signing

PLEASE ATTACH PATIENT LABEL OR PROVIDE:

NAME ____________________

MRN __________ FIN __________

Disclosure and Consent for Electroconvulsive Therapy

Electroconvulsive Therapy Client's Rights

1. You have the right to be treated with dignity in a humane and safe environment with appropriate respect for personal privacy.
2. You have the right to know the rules of this facility and any restrictions that are a part of your written treatment plan and how they affect your rights.
3. You have the right to know the cost of your treatment, the cost charged to other sources, what fees are paid to other resources and any \imitations placed on duration of services.
4. You have the right to privacy concerning your care and treatment. Information is given out only with your written consent.
5. You have the right to actively participate in the development and periodic review of your treatment plan.
6. You have the right to receive information about your treatment and your progress.
7. You have the right to learn the qualifications of any person treating you.
8. Unless there are legal restrictions, you have the civil and legal right of any other citizen.
9. If you entered this facility voluntarily, you have the right to leave at any time.
10. You have the right to give informed consent to, or refuse medication or refuse treatment. You have the right to know the consequences of such actions.
11. You have the right to refuse to participate in any research program without restricting your access to any other services the facility offers.
12. You have the right to read your case record at the conclusion of your treatment, in the presence of ECT staff with a physician's order.
13. You have the right to have justification documented in your record by the Medical Director, as to information he/she may consider harmful to you if released to outside sources.
14. You have the right to be free from abuse, mistreatment, neglect and exploitation.
15. You have the right to a Grievance Process.
16. You have the right to receive a complete explanation of these rights in a clear, non-technical language so that you are clear of their meaning, at any time during your treatment period.
17. The Medical Director has the right to restrict release of information to you deemed harmful to your well-being. Should this occur, you will be notified, and documentation of reason will be written in your chart.

I certify that:

- I have received a copy of this document.
- Staff have explained the content to me in a language that I understand.

______________________________ __________ ______

Client Signature Date Time

______________________________ __________ ______

Staff Signature Date Time