Authorization for Electroconvulsive Treatment

Patient’s Name: ________________________________

I hereby authorize Dr. ______________________________ to perform the following treatment:  
Electroconvulsive Treatment (ECT).

I understand that residents, medical students, physician assistants and/or advanced practice 
registered nurses may also be in attendance, and/or assisting in the performance, and/or performing 
significant medical/surgical tasks within the above specified treatment. In addition, I understand that 
there may be unforeseen circumstances that are encountered while performing the above listed 
treatment that require the assistance of other qualified medical personnel who have not been 
identified.

I have had explained to me in connection with the proposed treatment: (i) the nature and purpose of 
the proposed treatment; (ii) the foreseeable risks and consequences of the proposed treatment, 
including the risk that the proposed treatment may not achieve the desired objective; and (iii), the 
alternatives to the proposed treatment and the associated risks and benefits to such alternatives.

Electroconvulsive therapy is the most rapidly acting treatment for serious depressive illness and is 
also useful in certain other serious psychiatric conditions. A series of treatments is usually given. 
Each treatment consists of : 1) The use of an intravenous medication to produce sleep for 
approximately a five minute period; 2) The use of an intravenous agent to relax the muscles of the 
body; and 3) The induction of a very mild and well controlled convulsion from which the patient 
experiences little discomfort.

The indication(s) for ECT is this case are:

________________________________________________________________________________
________________________________________________________________________________

Specifically, in obtaining my informed consent to the Electroconvulsive Treatment, I have been 
informed of the following reasonably foreseeable risks:

• Short term memory loss for the period in which ECT was given which usually disappears in a 
few days up to 4 weeks following completion of the treatments.

• Fractures and dislocations which occur very rarely.

• Heart attack or stroke which are extremely rare.

• High blood pressure may occur during the treatment which is treated with medications may 
occur.

• Irregular heart rhythms.

• Death
I am aware that, in addition to the reasonably foreseeable risks described, there are other foreseeable risks, which have been discussed with me, but are not listed. I affirm that I understand the purpose and potential benefits of the proposed treatment and/or special procedure, that no guarantee has been made to me as to the results that may be obtained, and that an offer has been made to me to answer any of my questions about the proposed surgery/procedure/treatment.

I agree to the use of anesthesia and/or sedation/analgesia as required.

This consent may be revocable by me at any time, except to the extent it has already been relied upon.

______________________________________ M.D    Signed: ________________________________
Patient or legally authorized representative

Date_________   Time_________________   Date_________   Time_________________

Interpreter responsible for explaining procedures and special treatment:

_________________________________________________
Interpreter