Birmingham and Solihull NHS
Mental Health NHS Foundation Trust

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Electro-Convulsive Therapy Book
(Consent and details of treatment)

PATIENT DETAILS

Surname / Family Name…….

First Names…….

Date of Birth……

Consultant Psychiatrist……

Unit number……

NHS number……..

MHA legal status……..

Ward……

Ethnicity……..

Preferred language……..

Male / female

Special requirements……
……
……

Please complete all sections

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NOTES ON ELECTRO-CONVULSIVE THERAPY

AND CONSENT

Guidance to Health Professionals (to be read in conjunction with consent policy)

What a Consent Form is for.
This form documents the patient's agreement to go ahead with the investigation or treatment you have proposed. It is not a legal waiver – if patients, for example, do not receive enough information on which to base their decision, then the consent may not be valid, even though the form has been signed. Patients are also entitled to change their mind after signing the form, if they retain capacity to do so. The form should act as an aide-memoir to health professionals and patients by providing a checklist of the kind of information patients should be offered, and by enabling the patient to have a written record of the main points discussed. In no way, however, should the written information provided for the patient be regarded as a substitute for face-to-face discussions with the patient.

The Law on Consent.
See the Department of Health's Reference guide to consent for examination or treatment for a comprehensive summary of the law on consent (also available at **www.doh.gov.uk/consent**). (Information on the Consent Policy of Birmingham and Solihull Mental Health Foundation Trust can be found at http://sbmhtnt1/PoliciesandProcedures/C/C27_Consent.pdf)

Who Can Give Consent?
Everyone aged 16 or more is presumed to be competent to give consent for themselves, unless the opposite is demonstrated. Young people aged 16 and 17 may therefore sign this form for themselves, but may like a parent to countersign as well. **In all young people aged 16 or 17, the opinion of a SOAD will also be required.** Children under the age of 16 are not considered candidates for ECT. If a patient is mentally competent to give consent but is physically unable to sign a form you should complete this form as usual, and ask an independent witness to confirm that the patient has given consent orally or non-verbally.

When to Use This Form.
If the patient is 18 or over and is not legally competent to give consent, you should complete page 8-9 of this document. Form 4 (form for adults who are unable to consent to investigation or treatment) should not be used instead of this form. A patient will not be legally competent to give consent if:

- They are unable to comprehend and retain information material to the decision and/or
- They are unable to weigh and use this information is coming to a decision

You should always take all reasonable steps (for example involving more specialist colleagues) to support a patient in making their own decision, before concluding that they are unable to do so. Relatives **cannot** be asked to sign this form on behalf of an adult who is not legally competent to consent for him or herself.

Information.
Information about what the treatment will involve, its benefits and risks (including side-effects and complications) and the alternatives to the particular procedure proposed, is crucial for patients when making up their minds. The courts have stated that patients should be told about 'significant risks which would affect the judgement of a reasonable patient'. 'Significant' has not been legally defined but the GMC requires doctors to tell patients about 'serious or frequently occurring' risks. In addition if patients make clear they have particular concerns about certain kinds of risk, you should make sure they are informed about these risks, even if they are very small or rare. You should always answer questions honestly. Sometimes patients may make it clear that they do not want to have any information about the options but want you to decide on their behalf. In such circumstances you should do your best to ensure that the patient receives at least very basic information about what is proposed. Where information is refused you should document this on page 2 of the form and in the patient's notes.

It is considered good practise to allow a reasonable amount of time (at least 24 hours where possible) between imparting information to patients, and gaining their consent to treatment.

No patient should be put under duress to sign (e.g. 'if you do not sign, we will section you').

Patients who lack the capacity to make informed decisions for themselves should also receive such information as the Responsible Clinician feels is appropriate. This information should be shared with family or others who may advocate on the patients behalf, providing to do so would not compromise the clinicians' duty of confidence.

A flow chart follows which details the circumstances in which ECT may be administered to an incapacitated patient under the provisions of the Mental Health Act (amended 2007).

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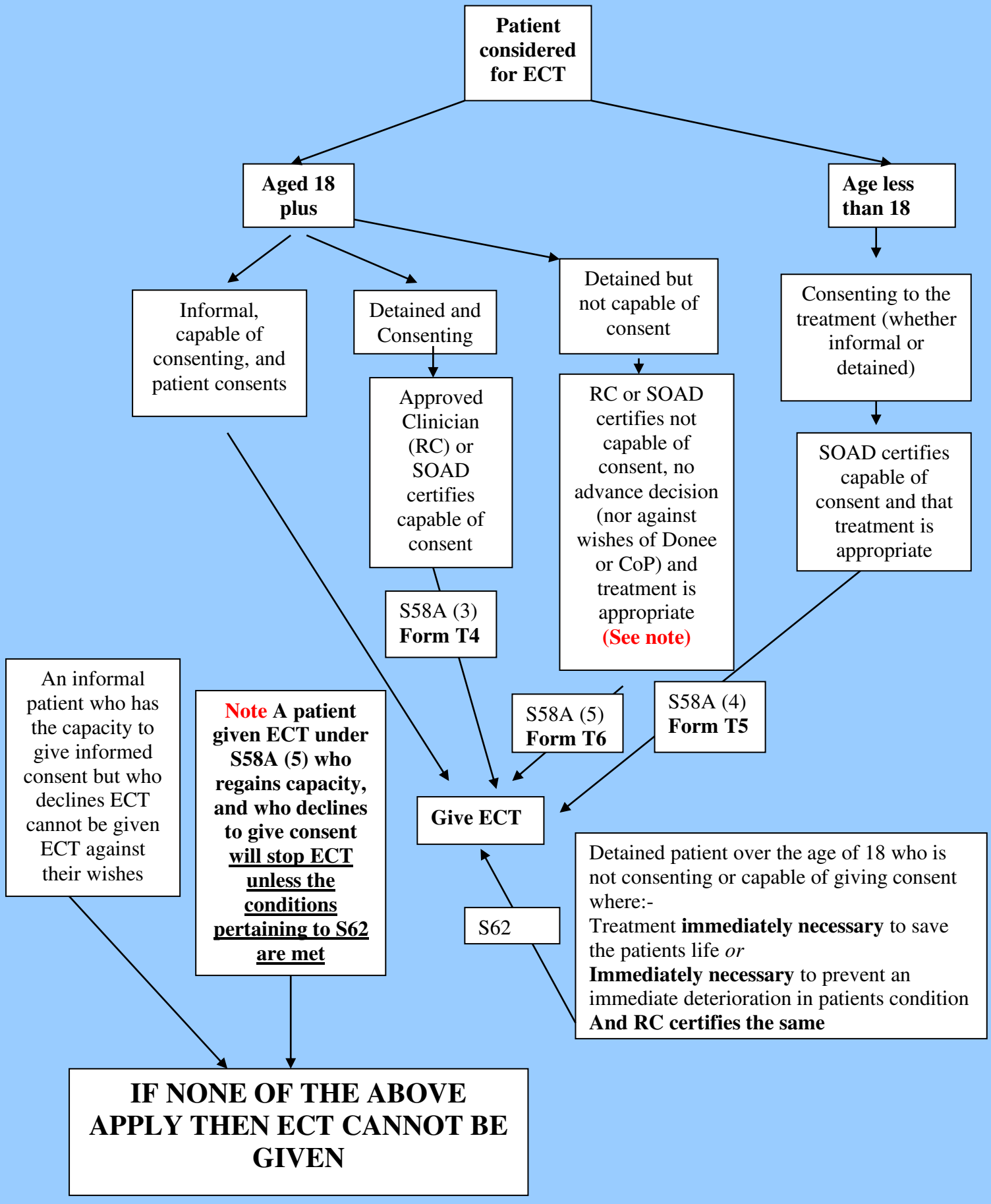
ECT and the MHA 2007

(Effective Nov 2008)



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CONSENT FORM FOR PATIENTS WITH THE CAPACITY TO GIVE INFORMED CONSENT

To be completed by

Responsible Clinician

And Patient

Birmingham and Solihull NHS
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Patient name…… Trust ICR Number……

CONSENT FORM FOR PATIENTS ABLE TO CONSENT

Name of proposed course of treatment

A course of bilateral / unilateral electro-convulsive therapy up to a maximum of twelve (12) / …….. Treatments.

STATEMENT OF RESPONSIBLE CLINICIAN

I have explained the procedure to the patient. In particular I have explained

The intended benefits:
- ☐ Reduction in depressive symptoms
- ☐ Reduction in negative / pessimistic thoughts
- ☐ Elevation of mood

Serious or frequently occurring risks:
- ☐ Memory loss (possibly permanent)
- ☐ Post treatment confusion

Transient side effects
- ☐ Loss of energy / drive
- ☐ headache
- ☐ Muscle aches
- ☐ Nausea
- ☐ Weakness
- ☐ 'Muzzy headedness'

I have also discussed what the procedure is likely to involve, the benefits and risks of alternative treatments (including no treatment) and any particular concerns of this patient.

This procedure will involve
General anaesthetic ☐ muscle relaxant ☐
The following leaflet has been provided: ECT information booklet ☐

I have been involved with those closest to the patient in a discussion of the treatment of …… (patients name). (Face to face / by telephone)

☐ I have explained that he/she has the capacity to refuse this treatment based on the criteria laid down in this form.

☐ I have explained that the patient does not have the capacity to refuse the treatment and being detained under the MHA, there being no advance decision or refusal by the Court of Protection or Donee, and the view of the Second Opinion Doctor supporting the Responsible Clinician, that the treatment may proceed.

Other concerns or comments raised about this decision……
……

☐ **The prescription of ECT for this patient adheres to the indications for ECT in NICE guidelines.**

☐ **The prescription of ECT for this patient does not adhere to the indications for ECT in NICE guidelines. I have produced a typed care plan in the patients ICR which explains the decision to proceed anyway.**

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Patient name…… Trust ICR Number……

☐ This patient is not detained under the Mental Health Act 1983/2007 and retains the capacity to give informed consent.

☐ This patient is detained under section….. of the Mental Health Act 1983/2007 but retains the capacity to give informed consent. A copy of my certificate (section 58A (3)) dated…… is attached.

☐ This 16 or 17-year-old patient is / is not detained under the Mental Health Act 1983/2007 and retains the capacity to give informed consent. A copy of the certificate (section 58A(4)) which confirms that they are capable of giving informed consent, and that such treatment is appropriate and which is signed by Dr…….. (Second Opinion Appointed Doctor) on (date)…… is attached.

Responsible Clinician proposing treatment……..

(Print name)……

Date…….

Job Title…….

Contact details……

Statement of Interpreter

I have interpreted the information above to the patient to the best of my ability and in a way which I believe s/he may understand

Signed…….

(Print name)……..

Date……

Top copy accepted by patient Yes ☐ No ☐

Birmingham and Solihull NHS
Mental Health NHS Foundation Trust

Patient name…… Trust ICR Number……

CONSENT FORM FOR PATIENTS ABLE TO CONSENT

Name of proposed course of treatment

A course of bilateral / unilateral electro-convulsive therapy up to a maximum of twelve (12) / …….. Treatments.

STATEMENT OF RESPONSIBLE CLINICIAN

I have explained the procedure to the patient. In particular I have explained

The intended benefits:
- ☐ Reduction in depressive symptoms
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- ☐ Elevation of mood

Serious or frequently occurring risks:
- ☐ Memory loss (possibly permanent)
- ☐ Post treatment confusion

Transient side effects
- ☐ Loss of energy / drive
- ☐ headache
- ☐ Muscle aches
- ☐ Nausea
- ☐ Weakness
- ☐ 'Muzzy headedness'

I have also discussed what the procedure is likely to involve, the benefits and risks of alternative treatments (including no treatment) and any particular concerns of this patient.

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I have been involved with those closest to the patient in a discussion of the treatment of …… (Patients name). (Face to face / by telephone)

☐ I have explained that he/she has the capacity to refuse this treatment based on the criteria laid down in this form.

☐ I have explained that the patient does not have the capacity to refuse the treatment and being detained under the MHA, there being no advance decision or refusal by the Court of Protection or Donee, and the view of the Second Opinion Doctor supporting the Responsible Clinician, that the treatment may proceed.

Other concerns or comments raised about this decision……
……

☐ **The prescription of ECT for this patient adheres to the indications for ECT in NICE guidelines.**

☐ **The prescription of ECT for this patient does not adhere to the indications for ECT in NICE guidelines. I have produced a typed care plan in the patients ICR which explains the decision to proceed anyway.**

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Patient name…… Trust ICR Number……

☐ This patient is not detained under the Mental Health Act 1983/2007 and retains the capacity to give informed consent.

☐ This patient is detained under section….. of the Mental Health Act 1983/2007 but retains the capacity to give informed consent. A copy of my certificate (section 58A (3)) dated…… is attached.

☐ This 16 or 17-year-old patient is / is not detained under the Mental Health Act 1983/2007 and retains the capacity to give informed consent. A copy of the certificate (section 58A(4)) which confirms that they are capable of giving informed consent, and that such treatment is appropriate and which is signed by Dr…….. (Second Opinion Appointed Doctor) on (date)…… is attached.

Responsible Clinician proposing treatment……..

(Print name)……

Date…….

Job Title…….

Contact details……

Statement of Interpreter

I have interpreted the information above to the patient to the best of my ability and in a way which I believe s/he may understand

Signed…….

(Print name)……..

Date……

Top copy accepted by patient Yes ☐ No ☐

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STATEMENT OF PATIENT

Patients name……

Trust ICR Number…….

Please read this information carefully. You should already have your own copy of pages 8 and 9 and an information booklet, which describes the benefits, and risks of ECT. If not you will be offered a copy now. If you have any further questions, do ask- we are here to help you. You have the right to change your mind **at any time**, including after you have signed this form.

I agree to the procedure and course of treatment described on this form.

I understand that no guarantee can be given that a particular person will perform the procedure. The person, however, will have appropriate experience.

I understand that I will have the opportunity to discuss the details of anaesthesia with an Anaesthetist before the procedure, unless the urgency of my situation prevents this.

I understand that any procedure(s) in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

I have been told about additional procedures which may become necessary during my treatment. I have listed below those procedures which **I do not wish** to be carried out without further discussion

……
……
……
……

Signed……Date……

Name (PRINT)……..

A witness should sign below if a patient has indicated their consent but cannot sign the form. Parents of young people may also sign here if requested to do so by the young person.

Signed……..Date……

Name (PRINT)……..

Patient withdrawing consent

I confirm that on (date)…… I withdrew my consent to the above procedure
Signed……..
Patient name……

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FORM FOR PATIENTS WHO LACK THE ABILITY TO GIVE INFORMED CONSENT

To be completed by Responsible Clinician

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Form for patients lacking capacity to consent

(All sections to be completed by clinician proposing treatment)

A Details of procedure or course of treatment proposed

Bilateral / unilateral Electro-convulsive therapy twice weekly up to a maximum of ….. Treatments

B Assessment of patients capacity to consent

I confirm the patient lacks capacity to give or withhold consent to this procedure because

☐ The patient is unable to comprehend and retain information material to the decision

And / Or

☐ The patient is unable to use and weigh this information in the decision making process.

Further details

(For example, explain how the above judgements were reached; which colleagues were consulted; what attempts were made to assist the patient make his or her own decision and why these were not successful)

……
……
…….

C Assessment of patients best interests

To the best of my knowledge, the patient has not refused this procedure in a valid advanced decision. Where possible and appropriate I have consulted with colleagues and those closest to the patient (including, if appropriate, an IMCA).

I believe the procedure to be in the patients best interests because……
……
……

Where incapacity is not likely to be permanent, the treatment cannot wait because
……
……
……

STATEMENT OF RESPONSIBLE CLINICIAN

☐ This patient is detained under section….. of the Mental Health Act 1983/2007 but lacks the capacity to give informed consent for the reasons stated above. I believe that the patient has not made an advanced decision expressly forbidding the prescribing of ECT, nor is it against the wishes of their Donee nor the Court of Protection. I believe that the treatment is appropriate.

A copy of SOADs' certificate (section 58A (5)) is attached.

☐ This patient is detained under section….. of the Mental Health Act 1983/2007 but lacks the capacity to give informed consent for the reasons stated above.

I believe that treatment is **immediately necessary** to save the patients life *or* **immediately necessary** to prevent an immediate deterioration in the patients condition.

A copy of my certificate (section 62) is attached

Clinician proposing treatment…….

Signed……..

Date…….

PLEASE NOTE

A patient who undergoes a course of ECT treatment under the provisions of S58A (5) (that is, where a SOAD provides a certificate) may conceivably regain capacity during their course of treatment.

If, once they have regained capacity, they decline to consent to further treatments they cannot be given further ECT unless to continue would meet the provisions of S62.

It is the responsibility of the referring team to **immediately** inform the ECT staff of any change in a patients' capacity to give informed consent, or in a patients' willingness to proceed with treatment.

A patient who regains capacity, having received a partial course of ECT under the provisions of section 58A (5), and who consents to carry on the course should be so certified by the Responsible clinician under section 58A (3).

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PRE-ECT ASSESSMENT

To be completed by Responsible Clinician or Deputy

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ECT RECORD FORM

Clinical information (to be completed by patients Consultant or deputy)

Main symptoms

	Yes
Depressed mood	☐
Depressive delusions	☐
Psychomotor retardation	
Psychomotor agitation	☐
Endogenous symptoms	☐
Other delusions	
Other motor disturbance	☐
Auditory hallucinations	☐
Other (please state)	

Medication at time of treatment

	Yes	Name/dose
Anti-convulsant	☐	……..
SSRI	☐	……..
Lithium		……..
Benzodiazepine		……..
Tricyclic	☐	……..
neuroleptic	☐	……..
steroid	☐	……..
MAOI	☐	……..
Other (please state)		……..

CHECKLIST (Factors which may raise seizure threshold or duration)

Aged over 65	☐	**Male**	☐
Baldness		**Benzodiazepines**	
Anti-convulsants	☐	**Centrally acting beta-blockers**	☐
L-tryptophan		**ECT in last month**	

OTHER CLINICAL INFORMATION

	YES	NO
Concentration difficulties evident before ECT?	☐	☐
Memory problems evident before ECT?	☐	☐
Previous courses of ECT?	☐	☐
(date…….. and how many treatments?……)		
Previous General anaesthetic?	☐	☐

Date…… Reason…….. Complications……..
……
……

Date of last menstrual period…… pregnancy test +ve / -ve
Date…….

Sickle test / thalassaemia test date…….. result…….
Hepatitis serology +ve / -ve date……..

Patients weight (kg)……

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ANAESTHETIC AND MEDICAL CHECKLIST

Date of physical exam …….
Date of most recent blood tests …….

HISTORY

Cardiovascular	**MI /PE/Angina/Hypertension**	**Yes** ☐	**No** ☐
Respiratory	**Asthma/Emphysema/Smoking history**	**Yes** ☐	**No** ☐
Neurological	**Epilepsy/CVA/TIA/Head injury**	**Yes** ☐	**No** ☐
Allergies		**Yes** ☐	**No** ☐
Other	**Jaundice/Diabetes/Eczema**	**Yes** ☐	**No** ☐

PRE-ANAESTHETIC ASSESSMENT

Assessment by Dr……..
Date ……

Referring Psychiatrist…….

Previous GAs…….
Airway ……
ASA 1 2 3 4 5

Dentition----------|----------

Notes

Regular Medications

Allergies

Investigations (as appropriate)

Height (m)
Weight (kg)

CXR

ECG

Date	Hb	Sickle/ Thal	WCC	Plat	INR	Na	K	Urea	Creat	Li	Others

DETAILS OF TREATMENT SESSIONS

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Part B TREATMENT CHECKLIST NURSING

ECT 1

Date												
	Ward	ECT	Ward	ECT	Ward	ECT	Ward	ECT	Ward	ECT	Ward	ECT
Name band?												
Correct clinical record?												
Correct prescription sheet?												
Correct blood results?												
Correct X-rays?												
Correct ECG?												
BP												
Pulse												
temp												
Recent change in physical health?												
Time patient last passed urine?												
Time patient last ate or drank?												
Jewellery/hair pins removed?												
Contact lenses removed												
Patient wears spectacles?												
Does patient have capped teeth?												
Does patient have hearing aid?												
Does patient have pacemaker?												
Initials ward nurse												
Initials ECT nurse												

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ECT#1 Date of treatment……

Treatment prescribed by …… Date of prescription……..
Print name …… Job title……

ANAESTHETIC	
Name of Anaesthetist	
Anaesthetic machine check Y/N	**Pre-ictal** P BP O_2 sats
Pre-Anaesthetic assessment (ASA) changed?	
IV site	
Pre oxygenation	
Anti-sialogogue	Dose (mg)
Induction agent	Dose (mg)
Muscle relaxant	Dose (mg)
Monitoring used	**NIBP Pulse O2 Sat ECG**
Anti-emetic	
Complications	
BVM/Airway/LMA/ET tube	**Post-ictal P BP O_2 sats**

CONSENT

Consent re-affirmed?	**Has capacity changed?**
Form T4/T5/T6 present and seen?	

ELECTRO CONVULSIVE THERAPY
Stimulation#1

Name of treating Psychiatrist	
Self test procedure successful?	
Electrode placement (Bi/LUL/RUL)	
Seizure pattern	
Dose of electricity	
Seizure length (visual) (s)	
Seizure length (EEG) (s)	
Complications?	

Stimulation #2

Self test procedure successful?	
Electrode placement	
Seizure pattern	
Dose of electricity	
Seizure length (visual)	
Seizure length (EEG)	
Complications?	

POST TREATMENT RECOVERY **Name of recovery nurse……..**

Time into recovery		**pulse**	**BP**	**O_2 Sats**	**Resp**	**Comments**
time						
Vital signs stable?		**i.v. access removed?**		**Time out of recovery**		

WARD ASSESSMENT

Changed Mood?		**Cognitive change?**	

Birmingham and Solihull NHS
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ECT#2 Date of treatment……

Treatment prescribed by …… Date of prescription……..
Print name …… Job title……

ANAESTHETIC	
Name of Anaesthetist	
Anaesthetic machine check Y/N	**Pre-ictal P BP O_2 sats**
Pre-Anaesthetic assessment (ASA) changed?	
IV site	
Pre oxygenation	
Anti-sialogogue	Dose (mg)
Induction agent	Dose (mg)
Muscle relaxant	Dose (mg)
Monitoring used	**NIBP Pulse O2 Sat ECG**
Anti-emetic	
Complications	
BVM/Airway/LMA/ET tube	**Post-ictal P BP O_2 sats**

CONSENT

Consent re-affirmed?	**Has capacity changed?**
Form T4/T5/T6 present and seen?	

ELECTRO CONVULSIVE THERAPY
Stimulation#1

Name of treating Psychiatrist	
Self test procedure successful?	
Electrode placement (Bi/LUL/RUL)	
Seizure pattern	
Dose of electricity	
Seizure length (visual) (s)	
Seizure length (EEG) (s)	
Complications?	

Stimulation #2

Self test procedure successful?	
Electrode placement	
Seizure pattern	
Dose of electricity	
Seizure length (visual)	
Seizure length (EEG)	
Complications?	

POST TREATMENT RECOVERY **Name of recovery nurse……..**

Time into recovery		**pulse**	**BP**	**O_2 Sats**	**Resp**	**Comments**
time						
Vital signs stable?		**i.v. access removed?**		**Time out of recovery**		

WARD ASSESSMENT

Changed Mood?		**Cognitive change?**	

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ECT#3 Date of treatment……

Treatment prescribed by …… Date of prescription……..
Print name …… Job title……

ANAESTHETIC	
Name of Anaethetist	
Anaesthetic machine check Y/N	**Pre-ictal P BP O_2 sats**
Pre-Anaesthetic assessment (ASA) changed?	
IV site	
Pre oxygenation	
Anti-sialogogue	Dose (mg)
Induction agent	Dose (mg)
Muscle relaxant	Dose (mg)
Monitoring used	**NIBP Pulse O2 Sat ECG**
Anti-emetic	
Complications	
BVM/airway/LNA ET tube	**Post-ictal P BP O_2 sats**

CONSENT

Consent re-affirmed?	**Has capacity changed?**
Form T4/T5/T6 present and seen?	

ELECTRO CONVULSIVE THERAPY
Stimulation#1

Name of treating Psychiatrist	
Self test procedure successful?	
Electrode placement (Bi/LUL/RUL)	
Seizure pattern	
Dose of electricity	
Seizure length (visual) (s)	
Seizure length (EEG) (s)	
Complications?	

Stimulation #2

Self test procedure successful?	
Electrode placement	
Seizure pattern	
Dose of electricity	
Seizure length (visual)	
Seizure length (EEG)	
Complications?	

POST TREATMENT RECOVERY **Name of recovery nurse……..**

Time into recovery		**pulse**	**BP**	**O_2 Sats**	**Resp**	**Comments**
time						
Vital signs stable?		**i.v. access removed?**		**Time out of recovery**		

WARD ASSESSMENT

Changed Mood?		**Cognitive change?**	

Birmingham and Solihull NHS
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ECT#4 Date of treatment……

Treatment prescribed by …… Date of prescription……..
Print name …… Job title……

ANAESTHETIC	
Name of Anaethetist	
Anaesthetic machine check Y/N	**Pre-ictal P BP O_2 sats**
Pre-Anaesthetic assessment (ASA) changed?	
IV site	
Pre oxygenation	
Anti-sialogogue	Dose (mg)
Induction agent	Dose (mg)
Muscle relaxant	Dose (mg)
Monitoring used	**NIBP Pulse O2 Sat ECG**
Anti-emetic	
Complications	
BVM/Airway/LMA/ET Tube	**Post-ictal P BP O_2 sats**

CONSENT

Consent re-affirmed?	**Has capacity changed?**
Form T4/T5/T6 present and seen?	

ELECTRO CONVULSIVE THERAPY
Stimulation#1

Name of treating Psychiatrist	
Self test procedure successful?	
Electrode placement (Bi/LUL/RUL)	
Seizure pattern	
Dose of electricity	
Seizure length (visual) (s)	
Seizure length (EEG) (s)	
Complications?	

Stimulation #2

Self test procedure successful?	
Electrode placement	
Seizure pattern	
Dose of electricity	
Seizure length (visual)	
Seizure length (EEG)	
Complications?	

POST TREATMENT RECOVERY **Name of recovery nurse……..**

Time into recovery		**pulse**	**BP**	**O_2 Sats**	**Resp**	**Comments**
time						
Vital signs stable?		**i.v. access removed?**		**Time out of recovery**		

WARD ASSESSMENT

Changed Mood?		**Cognitive change?**	

Birmingham and Solihull NHS
Mental Health NHS Foundation Trust

ECT#5 Date of treatment……

Treatment prescribed by …… Date of prescription……..
Print name …… Job title……

ANAESTHETIC	
Name of Anaethetist	
Anaesthetic machine check Y/N	**Pre-ictal P BP O_2 sats**
Pre-Anaesthetic assessment (ASA) changed?	
IV site	
Pre oxygenation	
Anti-sialogogue	Dose (mg)
Induction agent	Dose (mg)
Muscle relaxant	Dose (mg)
Monitoring used	**NIBP Pulse O2 Sat ECG**
Anti-emetic	
Complications	
BVM/airway/LMA/ET Tube	**Post-ictal P BP O_2 sats**

CONSENT

Consent re-affirmed?	**Has capacity changed?**
Form T4/T5/T6 present and seen?	

ELECTRO CONVULSIVE THERAPY
Stimulation#1

Name of treating Psychiatrist	
Self test procedure successful?	
Electrode placement (Bi/LUL/RUL)	
Seizure pattern	
Dose of electricity	
Seizure length (visual) (s)	
Seizure length (EEG) (s)	
Complications?	

Stimulation #2

Self test procedure successful?	
Electrode placement	
Seizure pattern	
Dose of electricity	
Seizure length (visual)	
Seizure length (EEG)	
Complications?	

POST TREATMENT RECOVERY **Name of recovery nurse……..**

Time into recovery		**pulse**	**BP**	**O_2 Sats**	**Resp**	**Comments**
time						
Vital signs stable?		**i.v. access removed?**		**Time out of recovery**		

WARD ASSESSMENT

Changed Mood?		**Cognitive change?**	

Birmingham and Solihull NHS
Mental Health NHS Foundation Trust

ECT#6 Date of treatment……

Treatment prescribed by …… Date of prescription……..
Print name …… Job title……

ANAESTHETIC	
Name of Anaethetist	
Anaesthetic machine check Y/N	**Pre-ictal P BP O_2 sats**
Pre-Anaesthetic assessment (ASA) changed?	
IV site	
Pre oxygenation	
Anti-sialogogue	Dose (mg)
Induction agent	Dose (mg)
Muscle relaxant	Dose (mg)
Monitoring used	**NIBP Pulse O2 Sat ECG**
Anti-emetic	
Complications	
BVM/Airway/LMA/ET tube	**Post-ictal P BP O_2 sats**

CONSENT

Consent re-affirmed?	**Has capacity changed?**
Form T4/T5/T6 present and seen?	

ELECTRO CONVULSIVE THERAPY
Stimulation#1

Name of treating Psychiatrist	
Self test procedure successful?	
Electrode placement (Bi/LUL/RUL)	
Seizure pattern	
Dose of electricity	
Seizure length (visual) (s)	
Seizure length (EEG) (s)	
Complications?	

Stimulation #2

Self test procedure successful?	
Electrode placement	
Seizure pattern	
Dose of electricity	
Seizure length (visual)	
Seizure length (EEG)	
Complications?	

POST TREATMENT RECOVERY **Name of recovery nurse…….**

Time into recovery		**pulse**	**BP**	**O_2 Sats**	**Resp**	**Comments**
time						
Vital signs stable?		**i.v. access removed?**		**Time out of recovery**		

WARD ASSESSMENT

Changed Mood?		**Cognitive change?**	

Birmingham and Solihull NHS
Mental Health NHS Foundation Trust

ECT#7 Date of treatment……

Treatment prescribed by …… Date of prescription……..
Print name …… Job title……

ANAESTHETIC	
Name of Anaethetist	
Anaesthetic machine check Y/N	**Pre-ictal P BP O_2 sats**
Pre-Anaesthetic assessment (ASA) changed?	
IV site	
Pre oxygenation	
Anti-sialogogue	Dose (mg)
Induction agent	Dose (mg)
Muscle relaxant	Dose (mg)
Monitoring used	**NIBP Pulse O2 Sat ECG**
Anti-emetic	
Complications	
BVM/Airway/LMA/ET tube	**Post-ictal P BP O_2 sats**

CONSENT

Consent re-affirmed?	**Has capacity changed?**
Form T4/T5/T6 present and seen?	

ELECTRO CONVULSIVE THERAPY
Stimulation#1

Name of treating Psychiatrist	
Self test procedure successful?	
Electrode placement (Bi/LUL/RUL)	
Seizure pattern	
Dose of electricity	
Seizure length (visual) (s)	
Seizure length (EEG) (s)	
Complications?	

Stimulation #2

Self test procedure successful?	
Electrode placement	
Seizure pattern	
Dose of electricity	
Seizure length (visual)	
Seizure length (EEG)	
Complications?	

POST TREATMENT RECOVERY **Name of recovery nurse…….**

Time into recovery		**pulse**	**BP**	**O_2 Sats**	**Resp**	**Comments**
time						
Vital signs stable?		**i.v. access removed?**		**Time out of recovery**		

WARD ASSESSMENT

Changed Mood?		**Cognitive change?**	

Birmingham and Solihull NHS
Mental Health NHS Foundation Trust

ECT#8 Date of treatment……

Treatment prescribed by …… Date of prescription……..
Print name …… Job title……

ANAESTHETIC	
Name of Anaethetist	
Anaesthetic machine check Y/N	**Pre-ictal P BP O_2 sats**
Pre-Anaesthetic assessment (ASA) changed?	
IV site	
Pre oxygenation	
Anti-sialogogue	Dose (mg)
Induction agent	Dose (mg)
Muscle relaxant	Dose (mg)
Monitoring used	**NIBP Pulse O2 Sat ECG**
Anti-emetic	
Complications	
BVM/Airway/LMA/ET tube	**Post-ictal P BP O_2 sats**

CONSENT

Consent re-affirmed?	**Has capacity changed?**
Form T4/T5/T6 present and seen?	

ELECTRO CONVULSIVE THERAPY
Stimulation#1

Name of treating Psychiatrist	
Self test procedure successful?	
Electrode placement (Bi/LUL/RUL)	
Seizure pattern	
Dose of electricity	
Seizure length (visual) (s)	
Seizure length (EEG) (s)	
Complications?	

Stimulation #2

Self test procedure successful?	
Electrode placement	
Seizure pattern	
Dose of electricity	
Seizure length (visual)	
Seizure length (EEG)	
Complications?	

POST TREATMENT RECOVERY **Name of recovery nurse……..**

Time into recovery		**pulse**	**BP**	**O_2 Sats**	**Resp**	**Comments**
time						
Vital signs stable?		**i.v. access removed?**		**Time out of recovery**		

WARD ASSESSMENT

Changed Mood?		**Cognitive change?**	

Birmingham and Solihull NHS
Mental Health NHS Foundation Trust

ECT#9 Date of treatment……

Treatment prescribed by …… Date of prescription……..
Print name …… Job title……

ANAESTHETIC	
Name of Anaethetist	
Anaesthetic machine check Y/N	**Pre-ictal P BP O_2 sats**
Pre-Anaesthetic assessment (ASA) changed?	
IV site	
Pre oxygenation	
Anti-sialogogue	Dose (mg)
Induction agent	Dose (mg)
Muscle relaxant	Dose (mg)
Monitoring used	**NIBP Pulse O2 Sat ECG**
Anti-emetic	
Complications	
BVM/airway/LMA/ET tube	**Post-ictal P BP O_2 sats**

CONSENT

Consent re-affirmed?	**Has capacity changed?**
Form T4/T5/T6 present and seen?	

ELECTRO CONVULSIVE THERAPY
Stimulation#1

Name of treating Psychiatrist	
Self test procedure successful?	
Electrode placement (Bi/LUL/RUL)	
Seizure pattern	
Dose of electricity	
Seizure length (visual) (s)	
Seizure length (EEG) (s)	
Complications?	

Stimulation #2

Self test procedure successful?	
Electrode placement	
Seizure pattern	
Dose of electricity	
Seizure length (visual)	
Seizure length (EEG)	
Complications?	

POST TREATMENT RECOVERY **Name of recovery nurse…….**

Time into recovery		**pulse**	**BP**	**O_2 Sats**	**Resp**	**Comments**
time						
Vital signs stable?		**i.v. access removed?**		**Time out of recovery**		

WARD ASSESSMENT

Changed Mood?		**Cognitive change?**	

Birmingham and Solihull NHS
Mental Health NHS Foundation Trust

ECT#10 **Date of treatment……**

Treatment prescribed by …… **Date of prescription……..**
Print name …… **Job title……**

ANAESTHETIC					
Name of Anaethetist					
Anaesthetic machine check Y/N	**Pre-ictal**	**P**	**BP**	**O_2 sats**	
Pre-Anaesthetic assessment (ASA) changed?					
IV site					
Pre oxygenation					
Anti-sialogogue			Dose (mg)		
Induction agent			Dose (mg)		
Muscle relaxant			Dose (mg)		
Monitoring used	**NIBP**	**Pulse**	**O2 Sat**	**ECG**	
Anti-emetic					
Complications					
BVM/Airway/LMA/ET tube	**Post-ictal**	**P**	**BP**	**O_2 sats**	

CONSENT

Consent re-affirmed?	**Has capacity changed?**
Form T4/T5/T6 present and seen?	

ELECTRO CONVULSIVE THERAPY
Stimulation#1

Name of treating Psychiatrist	
Self test procedure successful?	
Electrode placement (Bi/LUL/RUL)	
Seizure pattern	
Dose of electricity	
Seizure length (visual) (s)	
Seizure length (EEG) (s)	
Complications?	

Stimulation #2

Self test procedure successful?	
Electrode placement	
Seizure pattern	
Dose of electricity	
Seizure length (visual)	
Seizure length (EEG)	
Complications?	

POST TREATMENT RECOVERY **Name of recovery nurse……..**

Time into recovery		**pulse**	**BP**	**O_2 Sats**	**Resp**	**Comments**
time						
Vital signs stable?		**i.v. access removed?**		**Time out of recovery**		

WARD ASSESSMENT

Changed Mood?		**Cognitive change?**	

Birmingham and Solihull NHS
Mental Health NHS Foundation Trust

ECT#11 Date of treatment……

Treatment prescribed by …… Date of prescription……..
Print name …… Job title……

ANAESTHETIC	
Name of Anaethetist	
Anaesthetic machine check Y/N	**Pre-ictal P BP O_2 sats**
Pre-Anaesthetic assessment (ASA) changed?	
IV site	
Pre oxygenation	
Anti-sialogogue	Dose (mg)
Induction agent	Dose (mg)
Muscle relaxant	Dose (mg)
Monitoring used	**NIBP Pulse O2 Sat ECG**
Anti-emetic	
Complications	
BVM/Airway/LMA/ET tube	**Post-ictal P BP O_2 sats**

CONSENT

Consent re-affirmed?	**Has capacity changed?**
Form T4/T5/T6 present and seen?	

ELECTRO CONVULSIVE THERAPY
Stimulation#1

Name of treating Psychiatrist	
Self test procedure successful?	
Electrode placement (Bi/LUL/RUL)	
Seizure pattern	
Dose of electricity	
Seizure length (visual) (s)	
Seizure length (EEG) (s)	
Complications?	

Stimulation #2

Self test procedure successful?	
Electrode placement	
Seizure pattern	
Dose of electricity	
Seizure length (visual)	
Seizure length (EEG)	
Complications?	

POST TREATMENT RECOVERY **Name of recovery nurse……..**

Time into recovery		**pulse**	**BP**	**O_2 Sats**	**Resp**	**Comments**
time						
Vital signs stable?		**i.v. access removed?**		**Time out of recovery**		

WARD ASSESSMENT

Changed Mood?		**Cognitive change?**	

Birmingham and Solihull NHS
Mental Health NHS Foundation Trust

ECT#12 Date of treatment……

Treatment prescribed by …… Date of prescription……..
Print name

ANAESTHETIC	
Name of Anaethetist	
Anaesthetic machine check Y/N	**Pre-ictal P BP O_2 sats**
Pre-Anaesthetic assessment (ASA) changed?	
IV site	
Pre oxygenation	
Anti-sialogogue	Dose (mg)
Induction agent	Dose (mg)
Muscle relaxant	Dose (mg)
Monitoring used	**NIBP Pulse O2 Sat ECG**
Anti-emetic	
Complications	
BVM/Airway/LMA/ET tube	**Post-ictal P BP O_2 sats**

CONSENT

Consent re-affirmed?	**Has capacity changed?**
Form T4/T5/T6 present and seen?	

ELECTRO CONVULSIVE THERAPY
Stimulation#1

Name of treating Psychiatrist	
Self test procedure successful?	
Electrode placement (Bi/LUL/RUL)	
Seizure pattern	
Dose of electricity	
Seizure length (visual) (s)	
Seizure length (EEG) (s)	
Complications?	

Stimulation #2

Self test procedure successful?	
Electrode placement	
Seizure pattern	
Dose of electricity	
Seizure length (visual)	
Seizure length (EEG)	
Complications?	

POST TREATMENT RECOVERY **Name of recovery nurse……..**

Time into recovery		**pulse**	**BP**	**O_2 Sats**	**Resp**	**Comments**
time						
Vital signs stable?		**i.v. access removed?**		**Time out of recovery**		

WARD ASSESSMENT

Changed Mood?		**Cognitive change?**	

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GUIDANCE FOR ALL ECT DAY PATIENTS

If you are having Out-patient ECT, please take time to read this note carefully and show it to whoever will be looking after you when you go home.

Before ECT you must:-

Not have anything to eat or drink after midnight on the day before your treatment (6 hours before).

If you are taking tablets for a medical condition, take them at 6am on the morning of your treatment (with a small sip of water if necessary).

If you take tablets or insulin for diabetes, DO NOT take these on the morning of your treatment. Bring them with you so that you can receive them after your treatment.

Let the ECT department know if you develop a cold or any other new illness that may affect you receiving an anaesthetic.

Transport can be arranged, but it would be best if a friend or relative can drive you to and from the hospital. You should arrive at 8.45am and should be ready to go home by about 11am.

After ECT

You will have just had a general anaesthetic, therefore, you must:

- Be supervised by an adult at least until the following morning.
- Not leave hospital if you are feeling unsteady on your feet or confused.
- Not drive, ride a bike or operate any machinery or appliances for 24 hours.
- Not be left in sole charge of children until the following morning.
- Not sign any legal document or make important decisions for 24 hours.
- Not consume alcohol for 24 hours.

If you are concerned about how you are feeling, do not hesitate to contact your care co-ordinator, or during the evening, an emergency G.P. If you are having difficulty getting help, you could go to the A&E department and ask to speak with the psychiatrist on call for the hospital. Some people may develop a headache after treatment. This usually responds to paracetamol (2 x 500mg tablets).

Please note that the advice regarding driving refers to advice given to patients undergoing day case anaesthesia. For most of the psychiatric conditions for which ECT is prescribed, the DVLA advises at least 3 months elapses after recovery, before the patient recommences driving.

ECT for Outpatients

1) I confirm that I have read and understood the above guidelines. Signed …… Date …… I will be taken home by ……	2) I confirm that I have read and understood the above guidelines. Signed …… Date …… I will be taken home by ……
3)I confirm that I have read and understood the above guidelines. Signed …… Date …… I will be taken home by ……	4) I confirm that I have read and understood the above guidelines. Signed …… Date …… I will be taken home by ……
5) I confirm that I have read and understood the above guidelines. Signed …… Date …… I will be taken home by ……	6) I confirm that I have read and understood the above guidelines. Signed …… Date …… I will be taken home by ……
7) I confirm that I have read and understood the above guidelines. Signed …… Date …… I will be taken home by ……	8) I confirm that I have read and understood the above guidelines. Signed …… Date …… I will be taken home by ……
9) I confirm that I have read and understood the above guidelines. Signed …… Date …… I will be taken home by ……	10) I confirm that I have read and understood the above guidelines. Signed …… Date …… I will be taken home by ……
11) I confirm that I have read and understood the above guidelines. Signed …… Date …… I will be taken home by ……	12) I confirm that I have read and understood the above guidelines. Signed …… Date …… I will be taken home by ……

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POST ECT

To be completed by Clinician 3 months after completion of course

Patients name……

This patients' mental state is:-

Recovered / improved / no change / worse

Indication for ECT……

Cognitive function is clinically:-

Recovered / improved / no change / worse Formal test used……..

Patient subjectively reports their cognitive state is:- Comments……...

Recovered / improved / no change / worse ……...

Patient directs they would / would not consider another course of ECT in the future unless / even if their life were in danger.

Signature of clinician……

Signature of patient…… Date……

To be completed by Clinician 6 months after completion of course

Patients name……

This patients' mental state is:-

Recovered / improved / no change / worse

Indication for ECT……

Cognitive function is clinically:-

Recovered / improved / no change / worse Formal test used……..

Patient subjectively reports their cognitive state is:- Comments……...

Recovered / improved / no change / worse ……..…

Patient directs they would / would not consider another course of ECT in the future unless / even if their life were in danger.

Signature of clinician……

Signature of patient…… Date……