



Consent for Electroconvulsive Therapy (ECT) PM Form 3.11.2

This form **must** be completed and signed by the recipient, and forwarded to the attending psychiatrist/treating provider who will submit it to Magellan Health Services of Arizona, Inc. with the Request for Electroconvulsive Therapy (ECT) form. Please provide all requested information, subject to applicable law. **Authorization for Electroconvulsive Therapy (ECT) will not be considered until all sections of this form are completed. Please print clearly.**

I. Doctor's Name and Treatable Condition

I hereby grant permission to Dr. _____ (my doctor) to administer ECT to me for the treatment of (name of the psychiatric condition): _____

II. Benefits & Risks

I have been informed of the potential benefit and risks of ECT as well as the procedure for its administration as follows:

Benefit: Improvement in the above psychiatric condition.

Risks: Irregularities in heart rate or rhythm, potential complications of general anesthesia, headache, nausea, muscle soreness, temporary confusion, problems with memory (gaps in memory for events that occurred in the weeks before treatment and/or trouble remembering events immediately before and during the day of each treatment); Other: _____

Specifically, my doctor has explained that these following medical conditions of mine may add to my risk for problems when I receive ECT: _____

III. Procedure

A muscle relaxant under brief anesthesia is given before treatment; electrodes are placed at specific locations on the head; the electric stimulation produces a brief (about 30 seconds) seizure in the brain. Generally, several sessions of ECT are given over time, usually three times a week.

Other procedures: _____

IV. Approval

- My doctor has explained the option of receiving no treatment and its potential consequences.
- I understand that ECT is not a cure and that there is a risk that I may not remain well, even if the ECT treatments help me.
- I understand that I will need ongoing medical treatment even after the ECT treatments end.
- I understand that the number of ECT treatments cannot be predicted ahead of time and that the number of ECT treatments I receive will depend on my response to this treatment and the medical judgment of my doctor.
- I also understand that this consent for ECT shall not extend beyond 12 sessions of ECT.
- I understand that my consent is voluntary and that I may withdraw my consent for and refuse ECT at any time.

The first expected session of ECT is (list date): _____ and my doctor has recommended _____ sessions overall.

I understand that all information gathered in the course of my treatment at _____ is confidential. However, confidential information may be disclosed without my consent in accordance with state and federal law. Examples of such disclosures include emergency situations involving a serious and imminent threat to a person or the public; the reporting of child or adult abuse or neglect; court-ordered disclosures; financial claims requirements and audit and program evaluations.

I understand that for purposes of my treatment, my treatment information may be discussed by other members of my Clinical Team, and other professionals at Magellan. Additionally, I understand that by signing this consent I am giving permission for ADHS/DBHS to access my information and records maintained by Magellan and/or its subcontracted providers concerning the provision of covered services.

I agree to participate in my treatment planning process to the best of my ability.

Recipient's Name (Print):

Recipient's Signature

Date

Signature of Parent/Legal Guardian Consenting for Care and Treatment

Date

Signature of Staff Member (Witness)

Date

Office Use Only

Recipient Name:

Recipient ID