Freedom of Information Request

Reference Number: EPUT.FOI.20.1486
Date Received: 10 March 2020

Information Requested:

Could I please request the Electroconvulsive Therapy (ECT) informed consent paperwork for the following clinics?

1. Linden Centre, Chelmsford
2. Colchester
3. ECT Suite, Basildon Hospital

Response:

Please see attached.

Publication Scheme:

As part of the Freedom of Information Act all public organisations are required to proactively publish certain classes of information on a Publication Scheme. A publication scheme is a guide to the information that is held by the organisation. EPUT’s Publication Scheme is located on its Website at the following link https://eput.nhs.uk
### PATIENT AGREEMENT TO ELECTROCONVULSIVE THERAPY (ECT)

<table>
<thead>
<tr>
<th>Patient's full name</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth</td>
<td>U Male U Female</td>
</tr>
<tr>
<td>REMEDY number</td>
<td>NHS Number</td>
</tr>
<tr>
<td>Responsible Health Professional</td>
<td></td>
</tr>
<tr>
<td>Job Title</td>
<td></td>
</tr>
</tbody>
</table>

Special Requirements (e.g. Other language/other communication method)

A Course of Electroconvulsive Therapy up to a maximum of ______ treatments. (This section must be completed. If no number is not stated then treatment will not be given).

**Statement of health professional** (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)

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

- The intended benefits
  - reduction of depressive symptoms
  - reduction in negative/pessimistic thoughts
  - elevation in mood

Serious or frequently occurring risks
- memory loss (possibly permanent)
- post-treatment confusion
- loss of energy/drive

Transient side-effects
- headache
- muscle aches
- nausea
- 'muzzyheadedness'
- weakness

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

The following leaflet has been provided - ECT Information Booklet

This procedure will involve:
- U general anaesthesia
- U muscle relaxation
- U benzodiazepines

Signed   Date

Name (PRINT)

Job title

Responsible Clinician’s Signature (if different from above)

Contact details (if patient wishes to discuss options later)

**Statement of interpreter** (where appropriate)

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

Signed   Date

Name (PRINT)

Top copy accepted by patient: yes/no (please ring)  To be retained in patient's notes
Statement of patient

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy of the front page and an information booklet which describes the intended benefits and frequently occurring 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 you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, 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 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 any procedures which I do not wish to be carried out without further discussion.

<table>
<thead>
<tr>
<th>Patient's Name (PRINT)</th>
<th>Date</th>
</tr>
</thead>
</table>

A witness should sign below if the patient is unable to sign but has indicated his or her consent. Young people/children may also like a parent to sign here (see notes).

<table>
<thead>
<tr>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name (PRINT)</th>
<th>Date</th>
</tr>
</thead>
</table>

**Important notes: (tick if applicable)**

- See also advance directive/living will (eg Jehovah's Witness form)
Patient's Name | Remedy Number

**Confirmation or withdrawal of consent** (to be completed by a health professional each time the patient attends for the procedure, if the patient has signed the form in advance).

On behalf of the team treating the patient, I have confirmed with the patient that s/he has no further questions and wishes the procedure to go ahead. I have explained that the patient may withdraw consent at any time.

<table>
<thead>
<tr>
<th>Patient has withdrawn consent (ask patient to sign/date here)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Signed</td>
<td>Date</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If consent withdrawn, date of last treatment</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Signed</td>
<td>Date</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signed</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name (PRINT)</td>
<td>Job title</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signed</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name (PRINT)</td>
<td>Job title</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signed</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name (PRINT)</td>
<td>Job title</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signed</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name (PRINT)</td>
<td>Job title</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signed</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name (PRINT)</td>
<td>Job title</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signed</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name (PRINT)</td>
<td>Job title</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signed</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name (PRINT)</td>
<td>Job title</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signed</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name (PRINT)</td>
<td>Job title</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signed</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name (PRINT)</td>
<td>Job title</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signed</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name (PRINT)</td>
<td>Job title</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signed</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name (PRINT)</td>
<td>Job title</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signed</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name (PRINT)</td>
<td>Job title</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signed</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name (PRINT)</td>
<td>Job title</td>
</tr>
</tbody>
</table>

25
CONSENT FORM 5  Page 4 of 4

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-memoire to health professionals and patients, by providing a check-list 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).

Who can give consent
Everyone aged 16 or more is presumed to be competent to give consent for themselves, unless the opposite is demonstrated. If a child under the age of 16 has “sufficient understanding and intelligence to enable him or her to understand fully what is proposed”, then he or she will be competent to give consent for himself or herself. Young people aged 16 and 17, and legally ‘competent’ younger children, may therefore sign this form for themselves, but may like a parent to counter-sign as well. If the child is not able to give consent for himself or herself, some-one with parental responsibility may do so on their behalf and a separate form is available for this purpose. Even where a child is able to give consent for himself or herself, you should always involve those with parental responsibility in the child’s care, unless the child specifically asks you not to do so. 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.

If a patient refuses or cannot give their consent then the Mental Health Act procedures should be completed – the front part of the form should be completed and handed to the patient. Lack of capacity to give consent will be evidenced on form (MCA2) and we have a statutory obligation to provide an Independent Mental Capacity Advocate (IMCA).

When NOT to use this form
If the patient is 16 or over and is not legally competent to give consent, you should invoke the Mental Health Act and document using form 4 (form for adults who are unable to consent to investigation or treatment) 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 in 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 himself 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 to 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 or in the patient’s notes.
PATIENT AGREEMENT TO ELECTROCONVULSIVE THERAPY (ECT)

Patient’s full name _________________________ Date of Birth ___________

Remedy number _________________________ NHS Number _________________________

Responsible Health Professional _________________________ Job Title _________________________

Special Requirements) ____________________________________________________________________________
(eg Other language/other communication method)

A Course of Electroconvulsive Therapy up to a maximum of _____ treatments.
(This section must be completed. If a number is not stated then treatment will not be given).

Statement of health professional (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)

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

The intended benefits
- reduction of depressive symptoms
- reduction in negative/pessimistic thoughts
- elevation in mood

Serious or frequently occurring risks
- memory loss (possibly permanent)
- post-treatment confusion
- loss of energy/drive

Transient side-effects
- headache
- muscle aches
- ‘muzzyheadedness’
- weakness

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

☐ The following leaflet has been provided - ECT Information Booklet

This procedure will involve:
☐ general anaesthesia ☐ muscle relaxation ☐ benzodiazepines

Signed ___________________________________ Date _____________________________

Name (PRINT) ___________________________ Job title ___________________________

Consultant’s Signature (if different from above) ___________________________

Contact details (if patient wishes to discuss options later) ___________________________

Statement of interpreter (where appropriate)

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

Signed ___________________________________ Date _____________________________

Name (PRINT) ___________________________
Top copy accepted by patient: yes/no (please ring)

To be retained in patient’s notes
CONSENT FORM 5

Statement of patient

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy of the front page and an information booklet which describes the intended benefits and frequently occurring 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 you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, 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 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 any procedures which I do not wish to be carried out without further discussion

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

Patient’s signature ______________________________  Date_____________________________

Name (PRINT) __________________________________________

A witness should sign below if the patient is unable to sign but has indicated his or her consent. Young people/children may also like a parent to sign here (see notes).

Signature____________________________________ Date _____________________________

Name (PRINT) ___________________________________________________________________

Important notes: (tick if applicable)

☐ See also advance directive/living will (eg Jehovah’s Witness form)
CONSENT FORM 5

Patient’s Name ___________________________  Carebase Number ____________________

**Confirmation or withdrawal of consent** (to be completed by a health professional each time the patient attends for the procedure, if the patient has signed the form in advance).

On behalf of the team treating the patient, I have confirmed with the patient that s/he has no further questions and wishes the procedure to go ahead. I have explained that the patient may withdraw consent at any time.

Patient has withdrawn consent (ask patient to sign/date here) ______________________________

If consent withdrawn date of last treatment ______________________________________________

Signed _________________________________  Date _____________________________
Name (PRINT) ___________________________  Job title ___________________________

Signed _________________________________  Date _____________________________
Name (PRINT) ___________________________  Job title ___________________________

Signed _________________________________  Date _____________________________
Name (PRINT) ___________________________  Job title ___________________________

Signed _________________________________  Date _____________________________
Name (PRINT) ___________________________  Job title ___________________________

Signed _________________________________  Date _____________________________
Name (PRINT) ___________________________  Job title ___________________________

Signed _________________________________  Date _____________________________
Name (PRINT) ___________________________  Job title ___________________________

Signed _________________________________  Date _____________________________
Name (PRINT) ___________________________  Job title ___________________________

Signed _________________________________  Date _____________________________
Name (PRINT) ___________________________  Job title ___________________________
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-memoire to health professionals and patients, by providing a check-list 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).

Who can give consent
Everyone aged 16 or more is presumed to be competent to give consent for themselves, unless the opposite is demonstrated. If a child under the age of 16 has “sufficient understanding and intelligence to enable him or her to understand fully what is proposed”, then he or she will be competent to give consent for himself or herself. Young people aged 16 and 17, and legally ‘competent’ younger children, may therefore sign this form for themselves, but may like a parent to countersign as well. If the child is not able to give consent for himself or herself, some-one with parental responsibility may do so on their behalf and a separate form is available for this purpose. Even where a child is able to give consent for himself or herself, you should always involve those with parental responsibility in the child’s care, unless the child specifically asks you not to do so. 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.

If a patient refuses or cannot give their consent then the Mental Health Act procedures should be completed – the front part of the form should be completed and handed to the patient.

When NOT to use this form
If the patient is 18 or over and is not legally competent to give consent, you should invoke the Mental Health Act and document using form 4 (form for adults who are unable to consent to investigation or treatment) 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 in 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 himself 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 or in the patient’s notes.
ECT CONSENT FORM – PART A (for Consultant use)

SERVICE USER DETAILS

SURNAME

FIRST NAME(S)

DOB: GENDER:

CONSULTANT PSYCHIATRIST

NHS No: MPI No:

SPECIAL REQUIREMENTS

(other language, other communication methods etc.)

PLEASE NOTE

- Under no circumstances must the Service User be coerced into ECT, e.g. implying the MHA will be applied if the Service User refuses consent.

- Should the Service User’s capacity to consent to ECT be in doubt, the Trust ‘Capacity Assessment Form’ should be completed and attached to this Consent Form.

- Clinicians must comply with the MHA 1983 Code of Practice (revised 2008) relating to ECT. The relevant documentation must be completed and attached to this consent form.

- Should the service user be detained under the Mental Health Act (MHA), the consent still needs to be completed and the Mental Health Ace Commission Leaflet 3 should be given to the Service User.

- Should the Service User be under 18 years old, the Prescribing Consultant must adhere to MHA Code of Practice 2008

TO BE RETAINED IN SERVICE USER’S NOTES

SERVICE USER NAME

NHS NO
STATE BY PRESCRIBING PSYCHIATRIST OR NOMINATED PSYCHIATRIST

EITHER: A course of Unilateral Electro Convulsive Therapy up to a maximum of .......... treatments

OR: A Course of Bilateral Electro Convulsive Therapy up to a maximum of .......... treatments

I have explained: Nature of treatment
Description of the process
The Procedure will involve both (please tick below)

General Anaesthesia [ ] Muscle Relaxation [ ]

I have also explained: The likely benefits
Likelihood of success

I have pointed out: The risks of adverse effects
Likelihood of adverse effects (including dental damage)
Possibility of memory loss (occasionally permanent)
Transient side effects (post-treatment confusion)

I have discussed: The likely consequences of not having ECT
Treatment alternatives
Alternative treatments will be available if patient decides not have ECT

I have asked the Service User: If there are any further questions about any other particular concerns

The ‘ECT Information Booklet’ and a copy of this Consent Form have been provided (including those who are unable to consent. Include what additional verbal and/or written) information was discussed at the Service User’s request.

SIGNED PRINT NAME
DESIGNATION CONTACT DETAILS
DATE

STATEMENT OF INTERPRETER (where appropriate)

I have interpreted the information above to the Service User to the best of my ability and in a way in which I believe he/she can understand.

SIGNED
PRINT NAME DATE:

SERVICE USER NAME
STATEMENT OF SERVICE USER

Please read this form carefully. You should already have your own copy of page 2, and an ECT Information Booklet that describes the intended benefits and frequently occurring 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. Should you wish to obtain additional information or access to independent advocacy, please let us know.

You have the right to change your mind at any time, including after you have sign this form.

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

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will however, 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 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 informed about additional procedures which may become necessary during my treatment. I have listed below any procedures which I do not wish to be carried out without further discussion.

I understand that I have 24 hours to think about the ECT information provided. I can use this time to discuss the ECT with my relatives, friends and/or advisors. Only after this will I make a final decision about consenting for the treatment.

SERVICE USER’S SIGNATURE

PRINTED NAME:

A witness should sign below if the service user is unable to sign but has indicated his or her consent.

SIGNED: PRINT NAME:

DESIGNATION DATE:

IMPORTANT NOTES (Please tick if applicable)

☐ See Advanced Directive / Living Will (e.g. Jehovah’s Witness Form)
Service user’s relatives have been informed about the treatment. This does not conflict with issues relating to Service User confidentiality. Please document discussions in Service User’s notes.
CONSENT FORM – PART B (staff use only)
TO BE LINKED TO ‘PART A’ IN SERVICE USERS NOTES

SERVICE USER NAME ____________________________  NHS No __________

CONFIRMATION / WITHDRAWAL OF CONSENT
(Administering Psychiatrist to obtain consent before each SUBSEQUENT treatment) (Yes/No)

1. I have confirmed with the Service User that he/she has no further questions and wishes ECT to proceed

2. I have explained that he/she may withdraw consent at any time

3. I have confirmed with the Service User that he/she has not been coerced into accepting ECT, either at the base or in the ECT Suite (should SU allege coercion DO NOT administer ECT. Make entry in Clinical Notes)

TREATMENT No 1 (please tick appropriate)
Service User consents ☐ Service User does not consent ☐
Service User denies coercion ☐ Service User alleges coercion ☐

The consent and other relevant documentation has been discussed with Anaesthetist and ECT Nurse ☐

SIGNED: __________  PRINT NAME: __________  JOB TITLE: __________  DATE: __________

TREATMENT No 2 (please tick appropriate)
Service User consents ☐ Service User does not consent ☐ Original Consent Checked ☐
Service User denies coercion ☐ Service User alleges coercion ☐

The consent and other relevant documentation has been discussed with Anaesthetist and ECT Nurse ☐

SIGNED: __________  PRINT NAME: __________  JOB TITLE: __________  DATE: __________

TREATMENT No 3 (please tick appropriate)
Service User consents ☐ Service User does not consent ☐ Original Consent Checked ☐
Service User denies coercion ☐ Service User alleges coercion ☐

The consent and other relevant documentation has been discussed with Anaesthetist and ECT Nurse ☐

SIGNED: __________  PRINT NAME: __________  JOB TITLE: __________  DATE: __________

TREATMENT No 4 (please tick appropriate)
Service User consents ☐ Service User does not consent ☐ Original Consent Checked ☐
Service User denies coercion ☐ Service User alleges coercion ☐

The consent and other relevant documentation has been discussed with Anaesthetist and ECT Nurse ☐
ECT – Form 10 – Consent Form

SIGNED: ____________________________
PRINT NAME: ____________________________
JOB TITLE: ____________________________
DATE: ____________________________

TREATMENT No 5 (please tick appropriate)

Service User consents ☐ Service User does not consent ☐ Original Consent Checked ☐
Service User denies coercion ☐ Service User alleges coercion ☐

The consent and other relevant documentation has been discussed with Anaesthetist and ECT Nurse ☐

SIGNED: ____________________________
PRINT NAME: ____________________________
JOB TITLE: ____________________________
DATE: ____________________________

TREATMENT No 6 (please tick appropriate)

Service User consents ☐ Service User does not consent ☐ Original Consent Checked ☐
Service User denies coercion ☐ Service User alleges coercion ☐

The consent and other relevant documentation has been discussed with Anaesthetist and ECT Nurse ☐

SIGNED: ____________________________
PRINT NAME: ____________________________
JOB TITLE: ____________________________
DATE: ____________________________

TREATMENT No 7 (please tick appropriate)

Service User consents ☐ Service User does not consent ☐ Original Consent Checked ☐
Service User denies coercion ☐ Service User alleges coercion ☐

The consent and other relevant documentation has been discussed with Anaesthetist and ECT Nurse ☐

SIGNED: ____________________________
PRINT NAME: ____________________________
JOB TITLE: ____________________________
DATE: ____________________________

TREATMENT No 8 (please tick appropriate)

Service User consents ☐ Service User does not consent ☐ Original Consent Checked ☐
Service User denies coercion ☐ Service User alleges coercion ☐

The consent and other relevant documentation has been discussed with Anaesthetist and ECT Nurse ☐

SIGNED: ____________________________
PRINT NAME: ____________________________
JOB TITLE: ____________________________
DATE: ____________________________

TREATMENT No 9 (please tick appropriate)

Service User consents ☐ Service User does not consent ☐ Original Consent Checked ☐
Service User denies coercion ☐ Service User alleges coercion ☐
ECT – Form 10 – Consent Form

The consent and other relevant documentation has been discussed with Anaesthetist and ECT Nurse

SIGNED:  
PRINT NAME:  
JOB TITLE:  
DATE:  

TREATMENT No 10 (please tick appropriate)

Service User consents  
Service User does not consent  
Original Consent Checked  

Service User denies coercion  
Service User alleges coercion  

The consent and other relevant documentation has been discussed with Anaesthetist and ECT Nurse

SIGNED:  
PRINT NAME:  
JOB TITLE:  
DATE:  

TREATMENT No 11 (please tick appropriate)

Service User consents  
Service User does not consent  
Original Consent Checked  

Service User denies coercion  
Service User alleges coercion  

The consent and other relevant documentation has been discussed with Anaesthetist and ECT Nurse

SIGNED:  
PRINT NAME:  
JOB TITLE:  
DATE:  

TREATMENT No 12 (please tick appropriate)

Service User consents  
Service User does not consent  
Original Consent Checked  

Service User denies coercion  
Service User alleges coercion  

The consent and other relevant documentation has been discussed with Anaesthetist and ECT Nurse

SIGNED:  
PRINT NAME:  
JOB TITLE:  
DATE:  