DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH
CONSENT FOR ELECTROCONVULSIVE THERAPY (ECT)

_____
Child Name

Nature of mental illness: _____

_____

Recommendation (purpose of treatment, electrode placement, number of treatments, etc.):

_____

_____

Desired beneficial effects: _____

_____

Possible consequences of not receiving ECT: _____

_____

Possible side effects, if any: _____

_____

Plan for monitoring and management of side effects:

_____

_____

_____ _____
Child Signature Date Parent/Legal Guardian/Legal Custodian Signature Date

Regardless of whether you give or withhold consent, a due process procedure will be conducted before a panel of two Neutral and Detached Fact Finders (NDFF) to determine the appropriateness of such treatment.

I request to treat this child with Electroconvulsive Therapy (ECT)

_____
Physician Signature Date