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