

CARE RECORD: FOR PATIENTS RECEIVING ELECTROCONVULSIVE THERAPY

This care record is to be used with all patients who are receiving electroconvulsive therapy (ECT) within RDASH Mental Health Services. The care record starts once the decision to prescribe ECT has been made and ends once treatment has been discontinued. Any reasons for treatment being refused or withheld should be recorded on the discontinuation sheet.

Instructions for use:

Before writing in this care record please ensure you have signed the signature sheet. The care record documentation allows for up to 12 sessions of ECT to be administered. If more sessions are required this should be documented on 'Supplementary Sheet One'.

Overall care objectives:

- To perform the ECT procedure in a safe manner which produces minimum stress to the patient's physical and mental health.
- To initiate change in mental function to enable other interventions (nursing/medical/therapy etc) to be implemented.
- For patient to be made fully aware of procedures and understands possible benefits and side effects.
- Consult widely with patient/carer prior to administering ECT to ensure the patient/carer fully understands the process.
- To adhere to NICE Guidance on ECT (Technology Appraisal 59, April 2003).

The pre-commencement section of this care record (including physical examination) is to be completed by the patient's consultant or their deputy.

Abbreviations: ECT - Electroconvulsive Therapy

SOAD - Second Opinion Approved Doctor

Version 8 Page 1 of 45 Patient name: DOB:

DOB: Maracis No.:

Rotherham Doncaster and NHS

South Humber Mental Health

NHS Foundation Trust

Care Record for:

Patients receiving Electroconvulsive therapy

SIGNATURE SHEET

All disciplines writing in this care record must sign below prior to writing in it.

Full Name (print)	Designation	Signature	Initials	Date of Entry

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Patient name:

DOB:

Maracis No.:

Rotherham Doncaster and NHS
South Humber Mental Health
NHS Foundation Trust

Care Record for: Patients receiving Electroconvulsive therapy

PRIOR TO COMMENCING COURSE OF ECT (CONSENT)
CONSULTANT PSYCHIATRIST TO COMPLETE:
Mental Health Act Status: Informal ☐ Detained ☐ (specify section)
Informal Patient with capacity and consent form signed
Treatment under best interests form 4 completed
Consenting detained patient with capacity form T4 completed
Non consenting detained patient, without capacity, SOAD completed form T6 (Mental Health Act Commission leaflet No. 3 given)
Emergency treatment Section 62 completed
Patients under 18 who have consented, SOAD completed form T5
If other treatments have been considered, indicate which treatments.
Please indicate why ECT has been prescribed.
The ECT prescription falls within NICE (2003;2009) Guidelines (If no is indicated the reasons must be stated in the notes) No I recommend ECT for the above named Patient.
Unilateral Bilateral
Right Left L
Date Time Dr Signature Dr Name

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Patient name: DOB: Maracis No.:

TO BE COMPLETED BY THE CONSULTANT PSYCHIATRIST (or Section 12 approved doctor) PRIOR TO EACH TREATMENT SESSION – CLINICAL GLOBAL IMPRESSION SCALE (CGI) AND CAPACITY ASSESSMENT (WITHIN 24 HOURS PRIOR TO TREATMENT).

CLINICAL GLOBAL IMPRESSION (CGI)

1. Severity of Illness: Considering your total clinical experience with this particular population, how mentally ill is the patient at this time?

0 = Not assessed 4 = Moderately ill 1 = Normal, not at all ill 5 = Markedly ill 2 = Borderline mentally ill 6 = Severely ill

3 = Mildly ill 7 = Among the most extremely ill patients

2. Global improvement: Rate total improvement whether or not, in your judgement, it is due entirely to ECT treatment. Compared to hid/her condition at admission to the project, how much has he/she changed?

0 = Not assessed4 = No change1 = Very much improved5 = Minimally worse2 = Much improved6 = Much worse3 = Minimally improved7 = Very much worse

3. Efficacy index: Rate this item on the basis of ECT only. Select the terms which best describe the degrees of therapeutic effect and side effects and record the number in the box where the two items intersect.

EXAMPLE: Therapeutic effect is rated as 'Moderate' and side effects are judged 'Do not significantly interfere with the patient's functioning'.

Therapeutic effect		Side effects							
		None	Do not significantly interfere with patient's functioning	Significantly interferes with patient's functioning	Outweighs therapeutic effect				
Marked	Vast improvement. Complete or nearly complete remission of all symptoms.	01	02	03	04				
Moderate	Decided improvement. Partial remission of symptoms.	05	06	07	08				
Minimal	Slight improvement which doesn't alter status of care of patient.	09	10	11	12				
Unchanged or worse		13	14	15	16				
Not assessed = 00									

Reproduced from Guy W, editor. ECDEU Assessment Manuals for Psychopharmacology. 1976. Rockville, MD, U.S. Department of Health.

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Patient name:	DOB:	Maracis No.:
CAPACITY ASSESSMENT (must include de	etailed documentatio	on in the notes)
Capacity must be assessed within the 24 hour hours following treatment/any anaesthetic pro	•	t must not be assessed in the 24
If an advanced directive is known to exist, has Yes No III If no specify why	s it been taken into cor	nsideration?
Does the patient have capacity to give	valid consent for E	CT? Yes 🗆 No 🗆
Consent: Unless it is an emergency, prior consent to their Consultant Psychiatrist, consent, treatment must be authorised by Health Act Commission using a form T6.	or in the event of th	ne patient lacking capacity to give

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Patient name:	DOB:	Maracis No.:

CONSENT FORM Consultant Psychiatrist or nominated deputy to complete: Doctor's Explanation I confirm that I have explained to the patient the nature, purpose, and likely benefits of ECT and also the possible adverse effects/risks of this treatment, including temporary memory disturbances, memory loss (possibly permanent), headache, dental risk (identifying caps/crowns/bridges/dentures), muscle ache, nausea, fatigue, 'muzzy headedness' and temporary confusion. A test of capacity has taken place and the patient is able to give valid consent. I have also given the patient an information leaflet about ECT. I have discussed available alternative treatments (including no treatment) with the patient (documentation of the details of this is in the notes). Date _____ Time ____ Signed: **Patient's Consent** _____ of ___ Hereby consent to undergo to administration of Bilateral Unilateral ECT (electroconvulsive therapy), the nature, purpose and likely effects of which have been explained to me by Dr . Any concerns have been discussed. The maximum number of treatments I have consented to is 12. I also consent to the administration of general anaesthetic and muscle relaxant. I confirm that I have been given written information re ECT and I understand that an assurance has not been given that the treatment will be administered by a specific practitioner and understand that I may withdraw my consent at any time. Date Time Signed: Record of Discussion with Relative where appropriate I _____ of ____ and being the (State nature of relationship), confirm that an explanation of the nature, purpose and the likely effects of ECT (electroconvulsive therapy) were given to me by Dr _____ I have been given an information leaflet about ECT.

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Sianed: --

By relative

______ Date: _____ Time: ____

Rotherham Doncaster and NHS
South Humber Mental Health
NHS Foundation Trust

Care Record for Patients receiving Electroconvulsive therapy

PRIOR TO COMMEN	CING COURSE OF ECT (PHYSICAL AND MENTAL STA	ATE ASSESSMENT)							
Consultant Psychiatrist / Nominated Deputy to complete:									
Medical History include: existing health issues: heart disease (ischemic heart disease or hypertension, valvular heart disease or CHF, recent MI), chest diseases, diabetes, stroke, aneurysm, head injury, cerebral tumour, fracture, severe osteoporosis/rheumatoid arthritis, retinal detachment/glaucoma.									
Physical Examination:									
CVS: Respiratory:									
CNS:									
Abdomen:									
VTE									
Investigation	Result	Date							
FBC:									
U&E and other biochemistry:									
Other: e.g. sickle cell, Hep B, LFT.									
ECG									
Chest X-ray (if indicated):									
Diagnosis: Severe depre	essive illness Catatonia Mania Other (spec	cify)							
Mental State Assessmen	nt:								
Cognitive Assessment (MMSE, retrograde amnesia and assessment of subjec	tive memory							
impairment)									

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Patient na	me:			DC			is No.:	
			R TO COMMI					
Current Me	dication: (, frequency, d				141.)	
Name	Dose	Frequency	Date		Name	Dose	Frequency	Date
			Commenced					Commenced
				1				
Please dis	continue	Benzodiaze	epines and an	itico	onvulsants i	f possible	I .	1
Recently di	scontinue	d medicatior	n/illicit substan	ces	: (specify dru	ıg, frequenc	y, dose wher	n discontinued)
Name	Dose	Frequency	Date	1	Name	Dose	Frequency	Date
			Discontinued					Discontinued
_				1				
				-				
Allergies:		Pre	sent, indicate:					
		┌ Not	known					
ECT HISTO	ORY:							
Previous E		Yes \square	No 🗆					
			_	\neg				
If yes,	unilate		bilateral L					
How many	previous of	courses:						
Response t	to previous	s ECT:						
		•						
Date:	Time:		Signature:	Dr		No	me:	
Date.	111116.		Signature.	וט				
ANAETHE	STIST'S C	COMMENTS	: (if required)					
Date:	Time:		Signature:	Dr		Naı	me.	
			oignature.	ار 				

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Patient name:	DOB:	Maracis No.

Rotherham Doncaster and NHS
South Humber Mental Health
NHS Foundation Trust

Care Record for:

Patients receiving Electroconvulsive therapy

THEATRE CHECKLIST – TO BE COMPLETED BY WARD STAFF												
Ethnicity:												
Weight:	Kgs		Urir	ne test a	bnorma	lities:						
Could patient by pregnant?		n/a □ yes □ no □										
Does patient have/wear:		☐ dent	ures ctacles	_	apped te Oral pier			hearing	g aid.			
Ward: (If patient requires more than 1	_	outp		0250 11	50 2 SII	nnleme	ontary tl	neatre (shocklis	ot)		
Session	1	2	3	4	5	6	7	8	9	10	11	12
Date	•		3	-	3	•	'	0	3	10		12
Time												
Correct patient (ID band/label) Allergies written in red on wristband (see guidelines)												
Correct case notes/prescription/ ECT record												
Medication given Pre-ECT only as requested.												
ECT nurse informed of any abnormalities												
Consent form signed, or, MHA documentation in case notes												
Investigation results in case notes												
Physical observations recorded on treatment page.												
When did patient last pass urine (date/time)												
9. When did patient last eat/drink (date/time) Must be nil by mouth from 3am												
Make up/nail varnish removed												
11. Hair washed night before, not wearing gel etc												
12. Jewellery and hair pins removed												
12. Encouraged to empty bladder/bowels												
14. Completed Manual Handling Assessment available in notes.												
Staff Initials:												

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Patient name: DOB: Maracis No.:

THEATRE CHECKLIST TO BE COMPLETED BY PRE-TREATMENT ECT STAFF

Session	1	2	3	4	5	6	7	8	9	10	11	12
Date												
Time												
16.Oral body piercings removed												
17. Artificial eyes/contact lenses removed.												
18. Anaesthetist informed of any abnormalities												
19.Hearing aids/ spectacles removed												
20.Dentures removed												
21 Electrode sites prepared												
22. Diabetics only: blood glucose level.												
23. Patient's consent or appropriate forms checked.											_	
Staff Initials.												

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Patient	nt name: DOB: Maracis No.: DATE TREATMENT 1											
			DAIL			11	CLATIVILIVI					
						BILITIES:						
•	Important – specify medication changes Temperature: Pulse: BP: Oxygen Saturation:											
rempe	rature.		1	i disc.		ы.	Охуден	Cataration.				
	WARD MEDICAL STAFF RESPONISBILITIES: Pre treatment prescription tick boxes as											
approp	<u>riate</u> Iealth Act	t Stati	iie	Informa	, [Section	Please specify					
Consent		Jian		Informe	ed cons	sent (Consent	form and/or T4 comple					
						on (T5/T6 cor	•					
				,		m 4 complete	•					
FOT Due				•	-	,	ction 62 completed)	Ш				
ECT Pre	scription			Weekly Bilatera		Twice Weekl Unilateral	Y ∐ □ Right □ Left					
Date		Cons	sultant Pa	sychiatr	rist/Non	ninated Deput						
	TRISTS R			RECO	ORD 1 st Stim	nulation	2 nd Stimulation	3 rd Stimulation	=			
	nillicoulomb				ı Oun	ididilon	2 Guiridiation	o cumulation				
Setting (%	%)											
Seizure D	ouration obs	served										
Seizure D	uration EE	G										
Comment seizure)	ts (includino	g desc	ription of									
Date and	Time:				Psychi	atrists signati	ure:					
ANAESTI ASA Grad	HETIC REC	CORD	Comme	ents:								
Monitorin	ng (tick)		Drugs				IV Access	Airway				
BP			Thioper	ntone				Guedel				
ECG			Propofo	ol				Bite Block				
SaO2			Suxame	ethoniun	n		Gas Delivery 100% Oxygen by	LMA				
ETCO2			Other				Waters' circuit	ETT				
Date and	Time:		l		An	aesthetists Si	gnature:					
Observa	tions	Pre		Post	· ·	Recovery	Recovery Nurse Com	monte				
Observa	1110115		atment	Treat	ment	Recovery	(Including time to red					
Oxygen Saturation	nn.											
	л I											
Pulse												
BP												
Respirati	ion											

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Temperature

Patient name: DOB: Maracis No.:

TO BE COMPLETED BY THE CONSULTANT PSYCHIATRIST (or Section 12 approved doctor) PRIOR TO EACH TREATMENT SESSION – CLINICAL GLOBAL IMPRESSION SCALE (CGI) AND CAPACITY ASSESSMENT (WITHIN 24 HOURS PRIOR TO TREATMENT).

CLINICAL GLOBAL IMPRESSION (CGI)

1. Severity of Illness: Considering your total clinical experience with this particular population, how mentally ill is the patient at this time?

0 = Not assessed 4 = Moderately ill 1 = Normal, not at all ill 5 = Markedly ill 2 = Borderline mentally ill 6 = Severely ill

3 = Mildly ill 7 = Among the most extremely ill patients

2. Global improvement: Rate total improvement whether or not, in your judgement, it is due entirely to drug treatment. Compared to hid/her condition at admission to the project, how much has he/she changed?

0 = Not assessed4 = No change1 = Very much improved5 = Minimally worse2 = Much improved6 = Much worse3 = Minimally improved7 = Very much worse

3. Efficacy index: Rate this item on the basis of drug effect only. Select the terms which best describe the degrees of therapeutic effect and side effects and record the number in the box where the two items intersect.

EXAMPLE: Therapeutic effect is rated as 'Moderate' and side effects are judged 'Do not significantly interfere with the patient's functioning'.

Therapeutic effect		Side effects								
		None	Do not significantly interfere with patient's functioning	Significantly interferes with patient's functioning	Outweighs therapeutic effect					
Marked	Vast improvement. Complete or nearly complete remission of all symptoms.	01	02	03	04					
Moderate	Decided improvement. Partial remission of symptoms.	05	06	07	08					
Minimal	Slight improvement which doesn't alter status of care of patient.	09	10	11	12					
Unchanged or worse		13	14	15	16					
Not assessed = 00										

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Patient name:		DOB:	Maracis No.:							
CAPACITY ASSESSME	CAPACITY ASSESSMENT									
Must be completed by the Consultant Psychiatrist or Section 12 Approved doctor										
Has capacity changed since the last review? Yes No										
Does the patient have capacity to consent to ECT? Yes No										
Additional documentation should be completed in the notes to support the above assessment.										
DateTime	Signature		_							
Print name										

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Patient name:		DATE	DOB:	Maracı TREATMENT 2	s No.:			
WARD NURSING STAFF RESPONSIBILITIES: Important – specify medication changes								
Temperature:	•	ation cha Pulse:	nges BP:	Oxygen	Saturation:			
WARD MEDICAL STAFF RESPONISBILITIES: Pre treatment prescription tick boxes as								
appropriate Mental Health Act Status Informal Section Please specify Consent Informed consent (Consent form and/or T4 completed) Second Opinion (T5/T6 completed)								
	Best Int	•	form 4 complete	•				
FCT Draggring in the			,	ction 62 completed)				
ECT Prescription		Weekly [Bilateral [Twice Weekl Unilateral	´□ Right □ Left □				
Date	Consultant P	sychiatrist/l	Nominated Deput	y's Signature				
ECT TEAM TR	EATMENT	RECORD)					
PSYCHIATRISTS R	ECORD		Stimulation	2 nd Stimulation	3 rd Stimulation			
	OS							
Setting (%)								
Seizure Duration ob	served							
Seizure Duration EE	G							
Comments (includin seizure)	g description of							
Date and Time:		Psy	chiatrists signatu	ıre:				
ANAESTHETIC RE	CORD							
ASA Grade	Comme	ents:						
Monitoring (tick)	Drugs	Given		IV Access	Airway			
ВР	Thiope				Guedel			
ECG	Propofo	ol			Bite Block			
SaO2	Suxam	ethonium		Gas Delivery 100% Oxygen by	LMA			
ETCO2	Other			Waters' circuit	ETT			
Date and Time:			Anaesthetists Si	gnature:				
Observations	Pre	Post	Recovery	Recovery Nurse Com				
Oxygen	Treatment	Treatmer	nt Room	(Including time to rec	over)			
Saturation								
Pulse								
BP								
Respiration								

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Temperature

Patient name:	DOB:	Maracis No.:						
TO BE COMPLETED BY THE CONSU	JLTANT PSYCHIATR	IST (or Section 12 approved doctor))					
PRIOR TO EACH TREATMENT SESS			ND					
CAPACITY ASSESSMENT (WITHIN 2	4 HOURS PRIOR TO	TREATMENT).						
CLINICAL GLOBAL IMPRESSION (CGI)								
Severity of Illness: Considerin how mentally ill is the patient at	.	perience with this particular population	٦,					

0 = Not assessed 4 = Moderately ill 1 = Normal, not at all ill 5 = Markedly ill 2 = Borderline mentally ill 6 = Severely ill

3 = Mildly ill 7 = Among the most extremely ill patients

2. Global improvement: Rate total improvement whether or not, in your judgement, it is due entirely to drug treatment. Compared to hid/her condition at admission to the project, how much has he/she changed?

0 = Not assessed 4 = No change 1 = Very much improved 5 = Minimally worse 2 = Much improved 6 = Much worse 3 = Minimally improved 7 = Very much worse

3. Efficacy index: Rate this item on the basis of drug effect only. Select the terms which best describe the degrees of therapeutic effect and side effects and record the number in the box where the two items intersect.

EXAMPLE: Therapeutic effect is rated as 'Moderate' and side effects are judged 'Do not significantly interfere with the patient's functioning'.

Therapeutic effect		Side effects						
		None	Do not significantly interfere with patient's functioning	Significantly interferes with patient's functioning	Outweighs therapeutic effect			
Marked	Vast improvement. Complete or nearly complete remission of all symptoms.	01	02	03	04			
Moderate	Decided improvement. Partial remission of symptoms.	05	06	07	08			
Minimal	Slight improvement which doesn't alter status of care of patient.	09	10	11	12			
Unchanged or worse		13	14	15	16			
Not assessed = 00								

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CAPACITY ASSESSMENT

Must be completed by the Consultant Psychiatrist or Sec	tion 12 Approved doctor
Has capacity changed since the last review? Yes	No 🗀
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atient name	:			DC	D.	IN	/laracis	S NO.:		
Does the patio additional docu	ent hav umenta	ve capacity ation should	to consent to be completed	in t	CT? Yes he notes to s	□ support	No [[] t the ab	oove assess	sment.	
)ate	Time	e Si	gnature							
rint name			-				_			
Tille Hallio										
OATE:			INTERIM R	E\ //						
Consultant P	svchia	trists/ Nom								
			oleted by Cor			atrist/l	Nomin	ated Deput	у	
hysical Exam	ination	:								
CVS:										
Respiratory:										
NS:										
lbdomen:										
TE										
1 -										
Investigation	1			F	Result				Date	
FBC:										
U&E and other										
biochemistry:										
Other:LFT,sick e cell, Hep B.	I									
ECG (if										
indicated										
Chest X-ray (if indicated)										
Pregnancy test	t									
(if indicated) Mental State A	Assess	ment:								
Cognitive Ass	sessme	ent (MMSE,	retrograde a	mn	esia and ass	sessm	ent of	subjective	memory	
mpairment)										
Current Medica				ose		nence		Ι –	T -	
Name	Dose	Frequency	Date		Name		Dose	Frequency	Date	
			Commenced						Commenced	
				1						
						ļ				
lease discont	inue Be	enzodiazepin	es and antico	 	Isants if poss	sible				
Please discont	inue Be	enzodiazepin	es and antico Signature		•		Name:			

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Patient name:	DATE		DOB: T F	Maraci REATMENT 3	s No.:				
WARD NURSING STAFF RESPONSIBILITIES: Important – specify medication changes									
Temperature: Pulse: BP: Oxygen Saturation:									
	WARD MEDICAL STAFF RESPONISBILITIES: Pre treatment prescription tick boxes as								
	Appropriate Mental Health Act Status Consent Informal Section Please specify Informed consent (Consent form and/or T4 completed) Second Opinion (T5/T6 completed)								
	Best Int	,	orm 4 complete	•					
ECT Prescription		Emergency Weekly	Treatment (Sec Twice Weekl	ction 62 completed)					
-		Bilateral	Unilateral	□ Right □ Left □					
Date	Consultant P	sychiatrist/N	ominated Deput	y's Signature					
ECT TEAM TR	EATMENT	RECORD							
PSYCHIATRISTS R		1 st St	timulation	2 nd Stimulation	3 rd Stimulation				
Setting (%)									
Seizure Duration ob	served								
Seizure Duration El									
Comments (including									
seizure)	ig description of								
Date and Time:		Psyc	chiatrists signatu	ıre:					
ANAESTHETIC RE	CORD								
ASA Grade	Comme	ents:							
Monitoring (tick)	Drugs	Given		IV Access	Airway				
BP	Thioper	ntone			Guedel				
ECG	Propofo	ol			Bite Block				
SaO2	Suxamo	ethonium		Gas Delivery 100% Oxygen by	LMA				
ETCO2	Other			Waters' circuit	ETT				
Date and Time:	l .	-	Anaesthetists Si	gnature:					
Observations	Pre	Post	Recovery	Recovery Nurse Com	ments				
	Treatment	Treatment	-	(Including time to rec					
Oxygen Saturation									
Pulse									
BP									
Respiration									

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Temperature

Patient name: DOB: Maracis No.:

TO BE COMPLETED BY THE CONSULTANT PSYCHIATRIST (or Section 12 approved doctor) PRIOR TO EACH TREATMENT SESSION – CLINICAL GLOBAL IMPRESSION SCALE (CGI) AND CAPACITY ASSESSMENT (WITHIN 24 HOURS PRIOR TO TREATMENT).

CLINICAL GLOBAL IMPRESSION (CGI)

4. Severity of Illness: Considering your total clinical experience with this particular population, how mentally ill is the patient at this time?

0 = Not assessed 4 = Moderately ill 1 = Normal, not at all ill 5 = Markedly ill 2 = Borderline mentally ill 6 = Severely ill

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5. Global improvement: Rate total improvement whether or not, in your judgement, it is due entirely to drug treatment. Compared to hid/her condition at admission to the project, how much has he/she changed?

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6. Efficacy index: Rate this item on the basis of drug effect only. Select the terms which best describe the degrees of therapeutic effect and side effects and record the number in the box where the two items intersect.

EXAMPLE: Therapeutic effect is rated as 'Moderate' and side effects are judged 'Do not significantly interfere with the patient's functioning'.

Therapeutic effect		Side effects						
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Marked	Vast improvement. Complete or nearly complete remission of all symptoms.	01	02	03	04			
Moderate	Decided improvement. Partial remission of symptoms.	05	06	07	08			
Minimal	Slight improvement which doesn't alter status of care of patient.	09	10	11	12			
Unchanged		13	14	15	16			
or worse								
Not assessed = 00								

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Patient name:		DOB:	Ma	racis No.:				
CAPACITY ASSE	SSMENT							
Must be completed by the Consultant Psychiatrist or Section 12 Approved doctor								
Has capacity changed since the last review? Yes No								
Does the patient have capacity to consent to ECT? Yes No								
Additional documentation should be completed in the notes to support the above assessment.								
DateTi	ime	Signature						
Print name								

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Patient name:		DATE		DOB:	Т	Maracis REATMENT 4	No.:	
WARD NURSING STAFF RESPONSIBILITIES: Important – specify medication changes								
Temperature: Pulse: BP: Oxygen Saturation:								
•	AL STAFF	RESPO	NISE	BILITIES: Pi	re tre	eatment prescripti	on tick boxes as	
appropriate Mental Health Act Status Informal Section Please specify Consent Informed consent (Consent form and/or T4 completed)								
	Best Ir	iterest (Do	H for	m 4 complete	ed)			
		Emerger	ncy Tr	reatment (Sec	ction 6	62 completed)		
ECT Prescription		Weekly Bilateral		Twice Weekly Unilateral] Right □ Left □]	
Date	Consultant	Psychiatris	st/Non	minated Deput	y's Si	gnature		
ECT TEAM TR	FATMENT	RECOR	מא					
PSYCHIATRISTS R	ECORD			nulation	2	nd Stimulation	3 rd Stimulation	
Dose in millicoulomb	S							
Setting (%)								
Seizure Duration obs								
Seizure Duration EE	G							
Comments (including seizure)	g description o	f						
Date and Time:		Р	sychi	iatrists signatu	ure:			
ANAESTHETIC REC	CORD							
ASA Grade	Comn	nents:						
Monitoring (tick)	Drugs	Given			ľ	V Access	Airway	
BP		entone					Guedel	
ECG	Propo	fol					Bite Block	
SaO2	Suxar	nethonium			1	Sas Delivery 00% Oxygen by	LMA	
ETCO2	Other				V	Vaters' circuit	ETT	
Date and Time:	1		An	aesthetists Si	ignatu	re:	,	
Observations	Pre Treatment	Post Treatm	ent	Recovery Room		overy Nurse Comm		
Oxygen Saturation	Julinoill				,		· · · · /	
Pulse								
BP								
Respiration								

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Temperature

Patient nam	e:	DOB:	Maracis No.:
	PLETED BY THE CONSULTANT		
PRIOR TO E	ACH TREATMENT SESSION -	CLINICAL GLOBAL I	MPRESSION SCALE (CGI) AND
CAPACITY A	ASSESSMENT (WITHIN 24 HOU	RS PRIOR TO TREA	TMENT).
CLINICAL G	LOBAL IMPRESSION (CGI)		
	rity of Illness: Considering your to nentally ill is the patient at this time	•	e with this particular population,

0 = Not assessed 4 = Moderately ill 1 = Normal, not at all ill 5 = Markedly ill 2 = Borderline mentally ill 6 = Severely ill

3 = Mildly ill 7 = Among the most extremely ill patients

5. Global improvement: Rate total improvement whether or not, in your judgement, it is due entirely to drug treatment. Compared to hid/her condition at admission to the project, how much has he/she changed?

0 = Not assessed 4 = No change 1 = Very much improved 5 = Minimally worse 2 = Much improved 6 = Much worse 3 = Minimally improved 7 = Very much worse

6. Efficacy index: Rate this item on the basis of drug effect only. Select the terms which best describe the degrees of therapeutic effect and side effects and record the number in the box where the two items intersect.

EXAMPLE: Therapeutic effect is rated as 'Moderate' and side effects are judged 'Do not significantly interfere with the patient's functioning'.

Therapeutic effect		Side effects						
		None	Do not significantly interfere with patient's functioning	Significantly interferes with patient's functioning	Outweighs therapeutic effect			
Marked	Vast improvement. Complete or nearly complete remission of all symptoms.	01	02	03	04			
Moderate	Decided improvement. Partial remission of symptoms.	05	06	07	08			
Minimal	Slight improvement which doesn't alter status of care of patient.	09	10	11	12			
Unchanged or worse		13	14	15	16			
Not assessed = 00								

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CAPACITY ASSESSMENT

Must be completed by the Consultant Psychiatrist or Sect	tion 12 Approved doctor
Has capacity changed since the last review? Yes	No 🗀
Version 8	Page 21 of 45

oes the pati	ent hav	ve capacity	to consent to	o E(CT? Yes		10 [
dditional doc	umenta	ation should	be completed	in t	he notes to s	support t	he at	ove assess	sment.
ate	Time	e Si	gnature						
rint name									
DATE: Consultant F	Psvchia	trists/ Nom	INTERIM R inated deput						
			oleted by Cor			iatrist/No	omin	ated Deput	у
Physical Exam	nination								
CVS:									
Respiratory:									
CNS:									
Abdomen:									
/TE									
Investigation	n			F	Result				Date
FBC:									
U&E and other	r								
biochemistry:	el .								
Other:LFT,sicke cell, Hep B.	KI								
ECG (if									
indicated Chest X-ray (if	:								
indicated)									
Pregnancy tes (if indicated)	t								
Mental State	Assess	sment:							
Cognitive Ass	sessme	ent (MMSF	retrograde a	mn	esia and as	sessmei	nt of	subjective	memory
•	3033111	Siit (WiWOL,	retrograde a		cola alla ao	303311101		Subjective	illelilol y
mpairment)									
Current Medic	ation: (specify drug	, frequency, d	lose	, when com	menced)			
Name	Dose	Frequency	Date		Name	D	ose	Frequency	Date
			Commenced						Commenced
					•	I		1	1
Please discont	tinue Be	enzodiazepin	es and antico	- nvu	Isants if pos	sible			

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Patient name:	DATE		DOB: T F	Maraci REATMENT 5	s No.:					
	WARD NURSING STAFF RESPONSIBILITIES: Important – specify medication changes									
Temperature: Pulse: BP: Oxygen Saturation:										
WARD MEDICAL STAFF RESPONISBILITIES: Pre treatment prescription tick boxes as										
appropriate Mental Health Act Status Consent Informal Section Please specify Informed consent (Consent form and/or T4 completed) Second Opinion (T5/T6 completed)										
	Best In	,	form 4 complete	•						
ECT Prescription	,	Emergency Weekly	y Treatment (Sed	ction 62 completed)						
		Bilateral	Unilateral	□ Right □ Left						
Date	Consultant F	'sycniatrist/i	Nominated Deput	y's Signature						
ECT TEAM TR	REATMENT									
PSYCHIATRISTS F Dose in millicoulom		1 st S	Stimulation	2 nd Stimulation	3 rd Stimulation					
Setting (%)										
Seizure Duration ob	served									
Seizure Duration El										
Comments (including	ng description of	:								
seizure)										
Date and Time:		Psy	chiatrists signatu	ure:						
ANAESTHETIC RE	CORD									
ASA Grade	Comm	ents:								
Monitoring (tick)	Drugs	Given		IV Access	Airway					
BP	Thiope	entone			Guedel					
ECG	Propof	ol			Bite Block					
SaO2	Suxam	ethonium		Gas Delivery 100% Oxygen by	LMA					
ETCO2	Other			Waters' circuit	ETT					
Date and Time:	 		Anaesthetists Si	gnature:						
Observations	Pre	Post	Recovery	Recovery Nurse Com	nments					
Ovygon	Treatment	Treatmer		(Including time to rec						
Oxygen Saturation										
Pulse										
BP										
Respiration										

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Temperature

Patient name: DOB: Maracis No.:

TO BE COMPLETED BY THE CONSULTANT PSYCHIATRIST (or Section 12 approved doctor) PRIOR TO EACH TREATMENT SESSION – CLINICAL GLOBAL IMPRESSION SCALE (CGI) AND CAPACITY ASSESSMENT (WITHIN 24 HOURS PRIOR TO TREATMENT).

CLINICAL GLOBAL IMPRESSION (CGI)

7. Severity of Illness: Considering your total clinical experience with this particular population, how mentally ill is the patient at this time?

0 = Not assessed 4 = Moderately ill 1 = Normal, not at all ill 5 = Markedly ill 2 = Borderline mentally ill 6 = Severely ill

3 = Mildly ill 7 = Among the most extremely ill patients

8. Global improvement: Rate total improvement whether or not, in your judgement, it is due entirely to drug treatment. Compared to hid/her condition at admission to the project, how much has he/she changed?

0 = Not assessed 4 = No change 1 = Very much improved 5 = Minimally worse 2 = Much improved 6 = Much worse 3 = Minimally improved 7 = Very much worse

9. Efficacy index: Rate this item on the basis of drug effect only. Select the terms which best describe the degrees of therapeutic effect and side effects and record the number in the box where the two items intersect.

EXAMPLE: Therapeutic effect is rated as 'Moderate' and side effects are judged 'Do not significantly interfere with the patient's functioning'.

Therapeutic		Side effects						
effect								
		None	Do not significantly interfere with patient's functioning	Significantly interferes with patient's functioning	Outweighs therapeutic effect			
Marked	Vast improvement. Complete or nearly complete remission of all symptoms.	01	02	03	04			
Moderate	Decided improvement. Partial remission of symptoms.	05	06	07	08			
Minimal	Slight improvement which doesn't alter status of care of patient.	09	10	11	12			
Unchanged or worse		13	14	15	16			
Not assessed = 00								

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Version 8 Page 24 of 45

Patient name:		DOB:	Maracis No.:					
CAPACITY ASSE	ESSMENT							
Must be completed by the Consultant Psychiatrist or Section 12 Approved doctor								
Has capacity changed since the last review? Yes No								
Does the patient	have capaci	y to consent to ECT? Yes	□ No □					
Additional documentation should be completed in the notes to support the above assessment.								
DateT	ime	Signature						
Print name								

Version 8 Page 25 of 45

Patient	name:		Г	DATE		DOB:	TDE	Maracis EATMENT 6	No.:	
\\\\ \DD	A II I I DOIN)	IKL	ATWENT		
	<u>NURSIN</u> ant – spe					BILITIES:				
Tempe		SCITY		Pulse:	nang	BP:		Oxygen S	aturation:	
WARD MEDICAL STAFF RESPONISBILITIES: Pre treatment prescription tick boxes as										
approp Mental F	<u>rıate </u> lealth Act	Stati	us	Informa	, \sqsubset	Section [ase specify		
Consent				Informe	d cons		form and	d/or T4 complete		
			Best Inte	erest (D	oH for	m 4 complete	d)			
				Emerge	ency T	reatment (Sec	ction 62 c	ompleted)		
ECT Pre	scription			Weekly Bilatera		Twice Weekl Unilateral		ght □ Left □		
Date		Cons	sultant P	sychiatri	ist/Nor	ninated Deput	y's Signa	ture		
ECT TE	EAM TRE	ΕΑΤΙ	MENT	RECO	RD					
PSYCHIA	TRISTS RE	COR				nulation	2 nd S	Stimulation	3 rd Stimulatio	n
Dose in m	nillicoulomb	S								
Setting (%										
Seizure D	uration obs	erved								
	uration EE									
Comment seizure)	ts (including	desc	ription of							
Date and	Time:			ı	Psychi	iatrists signatı	ıre:			
ANAEST	HETIC REC	ORD								
ASA Grad			Comme	ents:						
NA it i-	(1:-1-)		D	0'			137.4		A:	
Monitorin BP	ng (tick)		Drugs (IV A	ccess	Airway Guedel	
ECG			Propofo	ol.					Bite Block	
SaO2			•	ethonium			Gas	Delivery	LMA	
ETCO2			Other		<u> </u>		100%	6 Oxygen by ers' circuit	ETT	
Date and	Times		Other			naesthetists Si		or or out		
Date and	Tillie.				Ail	idestrietists Si	gnature.			
Observa	itions	Pre	atment	Post Treatn	nont	Recovery Room		ery Nurse Comming time to reco		
Oxygen Saturatio	on	110	atment	Treati	ileilt	Koom	Includ	ing time to reco	ver	
Pulse										
BP										
Respirati	ion									

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Temperature

Patient name: TO BE COMPLETED BY THE CONSU PRIOR TO EACH TREATMENT SESS CAPACITY ASSESSMENT (WITHIN 2	ION – CLINICAL GL	RIST (or Section 12 approved doctor .OBAL IMPRESSION SCALE (CGI) A	•
CLINICAL GLOBAL IMPRESSION (CO	GI)		
7. Severity of Illness: Considering how mentally ill is the patient at	9 5	xperience with this particular population	n,
0 = Not assessed	4 = Moderately ill		
1 = Normal, not at all ill	5 = Markedly ill		
2 = Borderline mentally ill	6 = Severely ill		
3 = Mildly ill	7 = Among the m	ost extremely ill patients	
entirely to drug treatment. Comp has he/she changed?	pared to hid/her cond	her or not, in your judgement, it is due lition at admission to the project, how n	nuch
0 = Not assessed	4 = No change		
1 – Very much improved	5 – Minimally wo	nrea	

0 = Not assessed4 = No change1 = Very much improved5 = Minimally worse2 = Much improved6 = Much worse3 = Minimally improved7 = Very much worse

9. Efficacy index: Rate this item on the basis of drug effect only. Select the terms which best describe the degrees of therapeutic effect and side effects and record the number in the box where the two items intersect.

EXAMPLE: Therapeutic effect is rated as 'Moderate' and side effects are judged 'Do not significantly interfere with the patient's functioning'.

Therapeutic effect		Side effects							
		None	Do not significantly interfere with patient's functioning	Significantly interferes with patient's functioning	Outweighs therapeutic effect				
Marked	Vast improvement. Complete or nearly complete remission of all symptoms.	01	02	03	04				
Moderate	Decided improvement. Partial remission of symptoms.	05	06	07	08				
Minimal	Slight improvement which doesn't alter status of care of patient.	09	10	11	12				
Unchanged or worse		13	14	15	16				
Not assessed = 00									

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CAPACITY ASSESSMENT

Must be completed by the Consultant Psychiatrist or Sec	tion 12 Approved doctor
Has capacity changed since the last review? Yes	No 🗀
Version 8	Page 27 of 45

atient name	:			DC)B:	N	<i>M</i> araci:	s No.:	
Does the patio Additional doc	ent hav umenta	ve capacity ation should	to consent to be completed	o E0 ⊢in t	CT? Yes he notes to	suppor	No [[] t the at	oove assess	ment.
Date	Time	e Si	gnature				_		
Print name			•				_		
DATE:			INTERIM R	EV	IEW				
Consultant P						iotriot/	Mamin	oted Deput	v.
NTERIM REV		_	_					_	у
Physical Exam CVS:	IIIIalioii								
Respiratory:									
CNS:									
Abdomen:									
/TE									
Investigation	1			F	Result				Date
FBC:									
U&E and other									
biochemistry:									
Other:LFT,sick e cell, Hep B.	:1								
ECG (if									
indicated									
Chest X-ray (if indicated)									
Pregnancy test	t								
(if indicated) Viental State A	Δεερει	ement:							
Cognitive Ass			retrograde a	mn	esia and as	sessm	ent of	subjective	memory
mpairment)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, , , , , , , , , , , , , , , , , , ,	ron ogrado d		ooia aira ac	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0111 01	oubjoon vo	
mpammemy									
Current Medica	ation: (specify drug	, frequency, d	lose	, when com	mence	d)		
Name	Dose	Frequency	Date	1	Name		Dose	Frequency	Date
			Commenced						Commenced
		Ī							
Please discont	inue Ra	 enzodiazenin	es and antico	nvii	Isants if nos	sible			
Please discont	 <i>inue Be</i> Time:	ı enzodiazepin	es and antico Signature		-		Name:		

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Patient	name:		DATE			DOB:	Maracı REATMENT 7	s No.:			
							CEATHLINE 1				
	WARD NURSING STAFF RESPONSIBILITIES: Important – specify medication changes										
Tempe	•	Cury		Pulse:	_	BP:	Oxygen	Saturation:			
	WARD MEDICAL STAFF RESPONISBILITIES: Pre treatment prescription tick boxes as										
WARD approp		AL S	TAFF F	RESPO	ONISE	BILITIES: P	re treatment prescri	otion tick boxes	<u>as</u>		
Mental F	lealth Act	t Stat		Informa		Section	Please specify				
Consent	•					on (T5/T6 cor	: form and/or T4 comple npleted)	ted)			
			Best Inte	erest (D	OoH for	m 4 complete	ed)				
				Emerge	ency Tr	reatment (Sed	ction 62 completed)				
ECT Pre	scription			Weekly Bilatera		Twice Weekl	y □ □ Right □ Left				
Date		Cons				ninated Deput		<u> </u>			
	TRISTS R			RECO	RD 1 st Stim	vulation	2 nd Stimulation	3 rd Stimulation			
	nillicoulomb		<u> </u>		1 3111	idiation	2 Stillidation	3 Stirridiation			
Setting (%	%)										
Seizure D	uration obs	served									
Seizure D	uration EE	G									
Comment seizure)	ts (including	g desc	ription of					•			
Date and	Time:				Psychi	atrists signati	ure:				
ANAESTI	HETIC REC	COPO									
ASA Grad		JOND	Comme	ents:							
Monitorin BP	ng (tick)		Drugs (IV Access	Airway Guedel			
			·								
ECG			Propofo					Bite Block			
SaO2			Suxame	ethoniun	n		Gas Delivery 100% Oxygen by	LMA			
ETCO2			Other				Waters' circuit	ETT			
Date and	Time:				An	aesthetists Si	gnature:				
Observa	ntions	Pre		Post		Recovery	Recovery Nurse Com	nments			
0		Tre	atment	Treat	ment	Room	(Including time to red				
Oxygen Saturation	n										
Pulse											
BP											
Respirati	ion	1									

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Temperature

Patient name: DOB: Maracis No.:

TO BE COMPLETED BY THE CONSULTANT PSYCHIATRIST (or Section 12 approved doctor) PRIOR TO EACH TREATMENT SESSION – CLINICAL GLOBAL IMPRESSION SCALE (CGI) AND CAPACITY ASSESSMENT (WITHIN 24 HOURS PRIOR TO TREATMENT).

CLINICAL GLOBAL IMPRESSION (CGI)

10. Severity of Illness: Considering your total clinical experience with this particular population, how mentally ill is the patient at this time?

0 = Not assessed 4 = Moderately ill 1 = Normal, not at all ill 5 = Markedly ill 2 = Borderline mentally ill 6 = Severely ill

3 = Mildly ill 7 = Among the most extremely ill patients

11. Global improvement: Rate total improvement whether or not, in your judgement, it is due entirely to drug treatment. Compared to hid/her condition at admission to the project, how much has he/she changed?

0 = Not assessed4 = No change1 = Very much improved5 = Minimally worse2 = Much improved6 = Much worse3 = Minimally improved7 = Very much worse

12. Efficacy index: Rate this item on the basis of drug effect only. Select the terms which best describe the degrees of therapeutic effect and side effects and record the number in the box where the two items intersect.

EXAMPLE: Therapeutic effect is rated as 'Moderate' and side effects are judged 'Do not significantly interfere with the patient's functioning'.

Therapeutic		Side effects						
effect								
		None	Do not significantly interfere with patient's functioning	Significantly interferes with patient's functioning	Outweighs therapeutic effect			
Marked	Vast improvement. Complete or nearly complete remission of all symptoms.	01	02	03	04			
Moderate	Decided improvement. Partial remission of symptoms.	05	06	07	08			
Minimal	Slight improvement which doesn't alter status of care of patient.	09	10	11	12			
Unchanged or worse		13	14	15	16			
Not assessed = 00								

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Version 8 Page 30 of 45

Patient name:		DOB:	Maracis No.:						
CAPACITY ASSESS	SMENT								
Must be completed	by the Consultant Psycl	niatrist or Section 12	2 Approved doctor						
Has capacity changed since the last review? Yes No									
Does the patient ha	ve capacity to consent t	o ECT? Yes	No 🗀						
Additional document	ation should be completed	in the notes to suppo	ort the above assessment.						
DateTime	e Signature		_						
Print name									

Version 8 Page 31 of 45

Patient name:		DATE	DOB:	Maracı TREATMENT 8	s No.:				
WARD NURSII									
Important – sp Temperature:	•	ation cna Pulse:	nges BP:	Oxygen	Saturation:				
	AL STAFF F	RESPON	ISBILITIES: P	re treatment prescrip	otion tick boxes as				
appropriate Mental Health Ac Consent	t Status		Section consent (Consent pinion (T5/T6 cor	Please specify form and/or T4 complet npleted)					
	Best Int	,	form 4 complete	•					
FCT Dragorintion			•	ction 62 completed)					
ECT Prescription		Weekly [Bilateral [Twice Weekl Unilateral	´□ Right □ Left □					
Date	Consultant P	sychiatrist/	Nominated Deput	y's Signature					
ECT TEAM TR	EATMENT	RECORE)						
PSYCHIATRISTS R Dose in millicoulomb	ECORD		Stimulation	2 nd Stimulation	3 rd Stimulation				
	OS								
Setting (%)									
Seizure Duration ob	served								
Seizure Duration EE	G								
Comments (includin seizure)	g description of								
Date and Time:		Psy	ychiatrists signatı	ıre:					
ANAESTHETIC RE	CORD								
ASA Grade	Comme	ents:							
Monitoring (tick)	Drugs	Given		IV Access	Airway				
ВР	Thiope				Guedel				
ECG	Propofo	ol			Bite Block				
SaO2	Suxam	ethonium		Gas Delivery 100% Oxygen by	LMA				
ETCO2	Other			Waters' circuit	ETT				
Date and Time:			Anaesthetists Si	gnature:					
Observations	Pre	Post	Recovery	Recovery Nurse Com					
Oxygen	Treatment	Treatme	nt Room	(Including time to rec	over)				
Saturation									
Pulse									
BP									
Respiration		1							

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Temperature

Patient name: TO BE COMPLETED BY THE CONSULTANT PSYCHIATRIST (or Section 12 approved doctor) PRIOR TO EACH TREATMENT SESSION – CLINICAL GLOBAL IMPRESSION SCALE (CGI) AND CAPACITY ASSESSMENT (WITHIN 24 HOURS PRIOR TO TREATMENT).										
CLINICAL GLOBAL IMPRESSION (CGI)										
	at all ill	is time? 4 = Mo 5 = Mo 6 = Se			population,					
 11. Global improvement: Rate total improvement whether or not, in your judgement, it is due entirely to drug treatment. Compared to hid/her condition at admission to the project, how much has he/she changed? 0 = Not assessed										
describe where th EXAMPLE: The interfere with th	describe the degrees of therapeutic effect and side effects and record the number in the box where the two items intersect. EXAMPLE: Therapeutic effect is rated as 'Moderate' and side effects are judged 'Do not significantly interfere with the patient's functioning'.									
Therapeutic effect		Side e	ffects							
		None	Do not significantly interfere with patient's functioning	Significantly interferes with patient's functioning	Outweighs therapeutic effect					
Marked	Vast improvement. Complete or nearly complete remission of all symptoms.	01	02	03	04					
Moderate	Decided improvement. Partial remission of symptoms.	05	06	07	08					
Minimal	Slight improvement which doesn't alter status of care of patient.	09	10	11	12					
Unchanged or worse		13	14	15	16					
Not assessed = 00										
•	m Guy W, editor. ECDEU U.S. Department of Health		sment Manuals for I	Psychopharmacolog	y. 1976.					
CAPACITY AS	SESSMENT									
Must be comp	leted by the Consultant	<u>Psychia</u>	atrist or Section 1	2 Approved doctor						

Version 8 Page 33 of 45

No \square

Has capacity changed since the last review? Yes

oes the pati	ent hav	ve capacity	to consent to	o E(CT? Yes		No [
dditional doc	umenta	ation should	be completed	in t	he notes to	support	the at	ove assess	sment.
)ate	_ Time	e Si	gnature						
rint name									
DATE:			INTERIM R	EV	EW				
Consultant P NTERIM REV						iatrist/N	lomin	ated Denut	V
hysical Exam		_			-			_	,
CVS:									
Respiratory:									
CNS:									
Abdomen:									
/TE		••••••							
Investigation	Investigation Result								Date
FBC:									
U&E and other									
biochemistry: Other:LFT,sick	1								
e cell, Hep B.	.1								
ECG (if									
indicated Chest X-ray (if									
indicated) Pregnancy test	<u> </u>								
(if indicated)	L								
Mental State A	Assess	sment:							
Cognitive Ass	sessme	ent (MMSE,	retrograde a	mn	esia and as	sessme	ent of	subjective	memory
mpairment)		,	J						•
pa									
Current Medica	ation: (specify drug	, frequency, d	lose	, when com	menced)		
Name	Dose	Frequency	Date		Name		Dose	Frequency	Date
			Commenced						Commenced
								+	1
Please discont	inue Be	enzodiazepin	es and antico	 nvu	Isants if pos	sible			

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Patient	name:		DATE			DOB:	Maracı REATMENT 9	s No.:	
							CEATMENT 3		
	<u>NURSIN</u> ant – sp					BILITIES:			
Tempe	•	Cury		Pulse:	_	BP:	Oxygen	Saturation:	
							, ,		
WARD approp		AL S	TAFF F	RESPO	ONISE	BILITIES: P	re treatment prescri	otion tick boxes	<u>as</u>
	lealth Act	State		Informa		Section [Please specify		
Oonsen	-					on (T5/T6 cor			
			Best Inte	erest (D	OoH for	m 4 complete	d)		
				Emerge	ency Tı	reatment (Sed	ction 62 completed)		
ECT Pre	scription			Weekly Bilatera		Twice Weekl Unilateral	y □ □ Right □ Left		
Date		Cons				ninated Deput			
		- A T		DEGG					
	TRISTS R			RECO	1 st Stim	nulation	2 nd Stimulation	3 rd Stimulation	
Dose in millicoulombs									
Setting (%)									
Seizure D	ouration obs	served							
Seizure D	uration EE	G							
Comment seizure)	ts (includinç	g desc	ription of					·	
Date and	Time:				Psychi	atrists signati	ure:		
ANAEST	HETIC REC	CORD							
ASA Grad			Comme	ents:					
Monitorir	na (tick)		Drugs	Given			IV Access	Airway	
BP	ig (tick)		Thioper				TV Access	Guedel	
ECG			Propofo	ol				Bite Block	
SaO2			Suxame	ethoniun	n		Gas Delivery	LMA	
ETCO2			Other				100% Oxygen by Waters' circuit	ETT	
Date and	Time:				An	aesthetists Si	gnature:		
Observa	tions	Pre		Post	I	Recovery	Recovery Nurse Com	monte	
	1110115		atment	Treat	ment	Room	(Including time to red		
Oxygen Saturation	on								
Pulse									
BP									
Respirati	ion								

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Temperature

Patient name: DOB: Maracis No.:

TO BE COMPLETED BY THE CONSULTANT PSYCHIATRIST (or Section 12 approved doctor) PRIOR TO EACH TREATMENT SESSION – CLINICAL GLOBAL IMPRESSION SCALE (CGI) AND CAPACITY ASSESSMENT (WITHIN 24 HOURS PRIOR TO TREATMENT).

CLINICAL GLOBAL IMPRESSION (CGI)

13. Severity of Illness: Considering your total clinical experience with this particular population, how mentally ill is the patient at this time?

0 = Not assessed 4 = Moderately ill 1 = Normal, not at all ill 5 = Markedly ill 2 = Borderline mentally ill 6 = Severely ill

3 = Mildly ill 7 = Among the most extremely ill patients

14. Global improvement: Rate total improvement whether or not, in your judgement, it is due entirely to drug treatment. Compared to hid/her condition at admission to the project, how much has he/she changed?

0 = Not assessed 4 = No change 1 = Very much improved 5 = Minimally worse 2 = Much improved 6 = Much worse 3 = Minimally improved 7 = Very much worse

15. Efficacy index: Rate this item on the basis of drug effect only. Select the terms which best describe the degrees of therapeutic effect and side effects and record the number in the box where the two items intersect.

EXAMPLE: Therapeutic effect is rated as 'Moderate' and side effects are judged 'Do not significantly interfere with the patient's functioning'.

Therapeutic effect		Side effects							
		None	Do not significantly interfere with patient's functioning	Significantly interferes with patient's functioning	Outweighs therapeutic effect				
Marked	Vast improvement. Complete or nearly complete remission of all symptoms.	01	02	03	04				
Moderate	Decided improvement. Partial remission of symptoms.	05	06	07	08				
Minimal	Slight improvement which doesn't alter status of care of patient.	09	10	11	12				
Unchanged or worse		13	14	15	16				
Not assessed = 00									

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Patient name:		DOB:	Maracis No.:						
CAPACITY ASSESS	MENT								
Must be completed	by the <u>Consultant Psycl</u>	niatrist or Section 12	2 Approved doctor						
Has capacity changed since the last review? Yes No									
Does the patient ha	ve capacity to consent t	o ECT? Yes	No 🗀						
Additional documenta	ation should be completed	l in the notes to suppo	ort the above assessment.						
DateTime	e Signature		_						
Print name									

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Patient nai	me:		D	ATE		DOB:	Ma TREATMEN	aracis No.: T 10	
WARD NU			TAFF F	RESP			TKE/KIMEIK		
Important Temperatu		ecify		ation o Pulse:	_	es BP:	Оху	gen Saturation:	
		AL S	TAFF F	RESPO	ONISE	BILITIES: P	re treatment pre	escription tick boxes as	<u>s</u>
appropriate Mental Heal Consent		Stati			ed cons	Section Sent (Consent on (T5/T6 cor	form and/or T4 co	fympleted)	
			Best Inte	erest (C	OoH for	m 4 complete	d)		
				Emerg	ency Tı	reatment (Sed	ction 62 completed		
ECT Prescri	ption	_		Weekly Bilatera	al 🗀	Twice Weekl Unilateral	Č□ Right □ L	eft \square	
Date		Cons	sultant P	sychiati	rist/Non	minated Deput	y's Signature		
ECT TEAM	и TRE	EATI	MENT	RECO	RD				
PSYCHIATRI	PSYCHIATRISTS RECORD Dose in millicoulombs					nulation	2 nd Stimulation	3 rd Stimulation	
Setting (%)									
Seizure Durati									
Seizure Durati	ion EE0	G							
Comments (in seizure)	cluding	desc	ription of						
Date and Tim	ie:				Psychi	iatrists signati	ıre:		
ANAESTHET	IC REC	ORD							
ASA Grade			Comme	ents:					
Monitoring (t	ick)		Drugs				IV Access	Airway	
BP			Thioper	ntone				Guedel	
ECG			Propofo	ol				Bite Block	
SaO2				ethoniun	n		Gas Delivery 100% Oxygen b		
ETCO2			Other				Waters' circuit	ETT	
Date and Tim	ie:				An	naesthetists Si	gnature:		
Observation	าร	Pre Trea	atment	Post Treat	ment	Recovery Room	Recovery Nurse (Including time t		
Oxygen Saturation									
Pulse									
BP									
Respiration									

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Temperature

Patient name: TO BE COMPLETED BY THE CONSULTANT PSYCHIATRIST (or Section 12 approved doctor) PRIOR TO EACH TREATMENT SESSION – CLINICAL GLOBAL IMPRESSION SCALE (CGI) AND CAPACITY ASSESSMENT (WITHIN 24 HOURS PRIOR TO TREATMENT).										
CLINICAL GLOBAL IMPRESSION (CGI)										
	t at all ill	nis time? 4 = M 5 = M 6 = Se			population,					
 14. Global improvement: Rate total improvement whether or not, in your judgement, it is due entirely to drug treatment. Compared to hid/her condition at admission to the project, how much has he/she changed? 0 = Not assessed 1 = Very much improved 2 = Much improved 3 = Minimally improved 4 = No change 5 = Minimally worse 6 = Much worse 7 = Very much worse 15. Efficacy index: Rate this item on the basis of drug effect only. Select the terms which best describe the degrees of therapeutic effect and side effects and record the number in the box where the two items intersect. EXAMPLE: Therapeutic effect is rated as 'Moderate' and side effects are judged 'Do not significantly interfere with the patient's functioning'. 										
Therapeutic effect		Side e	ffects							
<u> </u>		None	Do not significantly interfere with patient's functioning	Significantly interferes with patient's functioning	Outweighs therapeutic effect					
Marked	Vast improvement. Complete or nearly complete remission of all symptoms.	01	02	03	04					
Moderate	Decided improvement. Partial remission of symptoms.	05	06	07	08					
Minimal	Slight improvement which doesn't alter status of care of patient.	09	10	11	12					
Unchanged or worse		13	14	15	16					
Not assessed = 00										
•		า.	sment Manuals for I							

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No \square

Has capacity changed since the last review? Yes

oos the noti	ont ho	vo consoity	to concept t	~ E/	T2 Vac =		No [
dditional doc	umenta	ation should	to consent to be completed	in t	he notes to			ove assess	sment.
)ate	_ Time	e Si	gnature				-		
rint name									
DATE: Consultant P	svchia	trists/ Nom	INTERIM R inated deput						
NTERIM REV						iatrist/N	lomin	ated Deput	у
hysical Exam	ination	:							
CVS:									
Respiratory:									
CNS:									
Abdomen:									
/TE									
Investigation Result								Date	
FBC:									
U&E and other									
biochemistry: Other:LFT,sick	1								
e cell, Hep B.	.1								
ECG (if									
indicated Chest X-ray (if									
indicated) Pregnancy test	+								
(if indicated)									
Mental State A	Assess	sment:							
Cognitive Ass	sessme	ent (MMSE,	retrograde a	mn	esia and as	sessme	ent of	subjective	memory
mpairment)			_					-	_
. ,									
Current Medica	ation: (specify drug	, frequency, d	lose	, when com	menced)		
Name	Dose	Frequency	Date		Name		Dose	Frequency	Date
			Commenced						Commenced
			1]				
				_					
Please discont	inue Be	enzodiazepin	es and antico	 	Isants if pos	sible			

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Patient	name:		DATE			DOB:	Mar REATMENT 11	acis No	D.:		
	NURSIN ant – spe					BILITIES: es					
Tempe	rature:			Pulse:		BP:	Oxyge	en Satı	uration:		
WARD approp		AL S	TAFF F	RESPO	ONISE	BILITIES: P	re treatment pres	cription	tick boxes	<u>as</u>	
	lealth Act	Stati			d cons	Section Esent (Consent on (T5/T6 cor	Please specify form and/or T4 comnpleted)]]	
				,		oH form 4 completed)					
507.				•	-	•	ction 62 completed)		L	J	
ECT Pre	scription			Weekly Bilatera		Twice Weekl Unilateral	y ∐ □ Right □ Le	eft \square			
Date		Cons	sultant Ps	sychiatr	ist/Non	ninated Deput	y's Signature				
FCT TE	EAM TRI	FΔTI	MENT	RECO	RD						
PSYCHIA	TRISTS RI	ECOR			1 st Stim	nulation	2 nd Stimulation		3 rd Stimulation		
Dose in m	nillicoulomb	S									
Setting (%	6)										
	uration obs										
Seizure D	ouration EE	G									
Comment seizure)	ts (including	desc	ription of								
Date and	Time:				Psychi	atrists signatı	ıre:				
ANAESTI	HETIC REC	ORD									
ASA Grad	de		Comme	ents:							
Monitorin	ng (tick)		Drugs (Given			IV Access	Α	irway		
BP			Thioper	ntone				G	uedel		
ECG			Propofo	ol				Ві	ite Block		
SaO2			Suxame	ethonium	1		Gas Delivery 100% Oxygen by		MA		
ETCO2			Other				Waters' circuit		TT		
Date and	Time:				An	aesthetists Si	gnature:				
Observa	ntions	Pre		Post		Recovery	Recovery Nurse C	Commen	ıts		
			atment	Treatr	ment	Room	(Including time to				
Oxygen Saturation	on										
Pulse											
BP											
Resnirati	ion										

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Temperature

Patient name: DOB: Maracis No.:

TO BE COMPLETED BY THE CONSULTANT PSYCHIATRIST (or Section 12 approved doctor) PRIOR TO EACH TREATMENT SESSION – CLINICAL GLOBAL IMPRESSION SCALE (CGI) AND CAPACITY ASSESSMENT (WITHIN 24 HOURS PRIOR TO TREATMENT).

CLINICAL GLOBAL IMPRESSION (CGI)

16. Severity of Illness: Considering your total clinical experience with this particular population, how mentally ill is the patient at this time?

0 = Not assessed 4 = Moderately ill 1 = Normal, not at all ill 5 = Markedly ill 2 = Borderline mentally ill 6 = Severely ill

3 = Mildly ill 7 = Among the most extremely ill patients

17. Global improvement: Rate total improvement whether or not, in your judgement, it is due entirely to drug treatment. Compared to hid/her condition at admission to the project, how much has he/she changed?

0 = Not assessed4 = No change1 = Very much improved5 = Minimally worse2 = Much improved6 = Much worse3 = Minimally improved7 = Very much worse

18. Efficacy index: Rate this item on the basis of drug effect only. Select the terms which best describe the degrees of therapeutic effect and side effects and record the number in the box where the two items intersect.

EXAMPLE: Therapeutic effect is rated as 'Moderate' and side effects are judged 'Do not significantly interfere with the patient's functioning'.

Therapeutic effect		Side effects					
		None	Do not significantly interfere with patient's functioning	Significantly interferes with patient's functioning	Outweighs therapeutic effect		
Marked	Vast improvement. Complete or nearly complete remission of all symptoms.	01	02	03	04		
Moderate	Decided improvement. Partial remission of symptoms.	05	06	07	08		
Minimal	Slight improvement which doesn't alter status of care of patient.	09	10	11	12		
Unchanged		13	14	15	16		
or worse							
Not assessed = 00							

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Patient name:		DOB:	Maracis No.:						
CAPACITY ASSESSMENT									
Must be completed by the Consultant Psychiatrist or Section 12 Approved doctor									
Has capacity changed since the last review? Yes No									
Does the patient have capacity to consent to ECT? Yes No									
Additional documentation should be completed in the notes to support the above assessment.									
DateT	ime	Signature							
Print name									

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Patient name: DATE			ΔTF	DOB:		Maracis No.: TREATMENT 12				
WARD NURSING STAFF RESPONSIBILITIES: Important – specify medication changes										
				Pulse:	_	BP:	Oxyger	Oxygen Saturation:		
WARD MEDICAL STAFF RESPONISBILITIES: Pre treatment prescription tick boxes as										
appropr		Stati	ıe	Informa	, [Section [Dloose specify			
Consent Informed consent (Consent form and/or T4 completed)										
Second Opinion (T5/T6 completed)										
Best Interest (DoH form 4 completed)										
Emergency Treatment (Section 62 completed) ECT Prescription Weekly Twice Weekly										
		C		Bilatera	al 🗀	Unilateral	T Right □ Left			
Date Consultant Psychiatrist/Nominated Deputy's Signature										
ECT TEAM TREATMENT RECORD										
PSYCHIA	TRISTS RE	COR			1 st Stim	nulation	2 nd Stimulation	3 rd Stimulation		
Dose in m	illicoulomb	3								
Setting (%	<u>,</u>									
Seizure Duration observed										
Seizure D	uration EE0	G								
Comments seizure)	s (including	desci	ription of					·		
Date and Time:				Psychiatrists signature:						
ANAESTI	HETIC REC	OBD		L.						
ASA Grad		OND	Comme	ents:						
Monitorin BP	g (tick)	Drugs Given Thiopentone					IV Access	Airway Guedel		
			•							
ECG			Propofol					Bite Block		
SaO2			Suxamethonium		า		Gas Delivery 100% Oxygen by	LMA		
ETCO2			Other	er e		Waters' circuit	ETT			
Date and Time: Anaesthetists Signature:										
Observations Pre Post Recovery Recovery Nurse Comments										
Oxygen		Trea	atment	Treati	ment	Room	(Including time to re	ecover)		
Saturatio	n									
Pulse										
BP										
Respirati	on									
respirati	UH									

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Temperature

DISCONTINUATION DECISION								
Consultant Psychiatrist Responsibilities								
Once the decision is made to discontinue treatment please complete the following:								
Number of sessions of ECT administered:								
Because for the continue time.								
Reasons for discontinuation: Desired clinical response achieved								
Poor clinical response: Physical Health problem Adverse event Consent withdrawn								
Comments								
-								
Date: Time: Signed:								

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