



MINISTRY OF HEALTH, MALAYSIA
DEPARTMENT OF PSYCHIATRY & MENTAL HEALTH
HOSPITAL _____ (name of hospital)

ECT PRESCRIPTION & REVIEW FORM (ECT-PRESCRIBE form)

INSTRUCTIONS: (1) This ECT-PRESCRIBE form is to be filled in each time the relevant ECT consent form is required.
(2) Please ensure information in this ECT-PRESCRIBE form is complete & correctly entered prior to certifying by the psychiatrist in-charge.

PATIENT'S NAME:			
RN / IC NO / AGE:	/ /		
GENDER:	<input type="checkbox"/> Male <input type="checkbox"/> Female		
SECTION 1: CURRENT ECT COURSE			
<p style="text-align: center;">From _____ (Date of first treatment session) to _____ (Date of last treatment session)</p> <p><input type="checkbox"/> ACUTE phase: for a period of up to four (4) weeks at a treatment interval of 2 or 3 sessions per week.</p> <p style="text-align: center;">OR</p> <p style="text-align: center;">From _____ (Date of first treatment session) to _____ (Date of last treatment session)</p> <p><input type="checkbox"/> CONTINUATION or MAINTENANCE phase: for a period of up to four (4) weeks at a treatment interval determined by the ECT Prescribing Psychiatrist.</p>			
Principal indication(s) for ECT prescription			
<p><input type="checkbox"/> Rapid definitive response is needed <input type="checkbox"/> Risks of other alternative treatment(s) outweigh risks of ECT</p> <p><input type="checkbox"/> Previous good response to ECT <input type="checkbox"/> Actively suicidal / Life-threatening situation</p> <p><input type="checkbox"/> Patient's preference <input type="checkbox"/> Other(s): _____</p>			
Psychiatric diagnosis (based on DSM-5)			Patient status
<input type="checkbox"/> Schizophrenia Spectrum & Other Psychotic Disorders Specify: _____ <input type="checkbox"/> Bipolar & Related Disorders Specify: _____ <input type="checkbox"/> Depressive Disorders Specify: _____ <input type="checkbox"/> Obsessive-Compulsive & Related Disorders Specify: _____ <input type="checkbox"/> Others Specify: _____			<input type="checkbox"/> Inpatient (Date of admission: _____) <input type="checkbox"/> Outpatient (Daycare)
			Admission status
			<input type="checkbox"/> Not applicable <input type="checkbox"/> Form 1 <input type="checkbox"/> Form 3 & Form 4 <input type="checkbox"/> Form 5 <input type="checkbox"/> Other(s): _____
Provision of consent		Read & understood ECT Information Sheet	
<input type="checkbox"/> Patient <input type="checkbox"/> Relative / Guardian <input type="checkbox"/> Two Psychiatrists		<input type="checkbox"/> Yes <input type="checkbox"/> No, state reason: _____	
Electrode placement	Stimulus pulse width	Handedness	
<input type="checkbox"/> Bilateral: <input type="checkbox"/> Temporal OR <input type="checkbox"/> Frontal <input type="checkbox"/> Unilateral: <input type="checkbox"/> Left OR <input type="checkbox"/> Right	<input type="checkbox"/> Brief <input type="checkbox"/> Ultra-brief <input type="checkbox"/> Others: _____	<input type="checkbox"/> Left <input type="checkbox"/> Right	



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SECTION 2: PREVIOUS ECT COURSE

Date of previous ECT treatment: _____
 No previous ECT treatment

Summary of previous ECT course (including number of treatment sessions, dose issues, adverse effects):

Previous ECT CGI (Clinical Global Impression) Improvement Scale

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

SECTION 3: MEDICAL REVIEW

Past medical history

Smoker Yes No

Current medication(s)

Pre-ECT systems review (✓ if present)

Shortness of breath Cough / sore throat Bleeding tendency Weakness / numbness Headache / dizziness Others, please state: _____
 Chest pain Fever Abdominal pain Seizure Dysuria None of the above

Medication allergies / sensitivities (state the medication, reaction & date)

Investigations (Summary of results)		Physical examination (Date: _____)
Results	Findings	
Full blood count Date: _____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal, please specify: <input type="checkbox"/> Not done, reason:	Height: _____ m Weight: _____ kg Temperature: _____ °C Heart rate: _____ bpm Respiratory rate: _____ BPM Blood pressure: _____ mmHg SpO ₂ : _____ %
Renal profile Date: _____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal, please specify: <input type="checkbox"/> Not done, reason:	Skull defect: (if Yes, with metal implant): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Chest X-Ray Date: _____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal, please specify: <input type="checkbox"/> Not done, reason:	Cochlear implant: <input type="checkbox"/> Yes <input type="checkbox"/> No Dentures: <input type="checkbox"/> Yes <input type="checkbox"/> No CIED (Cardiac implantable electronic device): <input type="checkbox"/> Yes <input type="checkbox"/> No
Electrocardiogram Date: _____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal, please specify: <input type="checkbox"/> Not done, reason:	Examination findings: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal If abnormal, please describe:

ECT-PRESCRIBE form reviewed by: _____

(Signature & Name: ECT Prescribing Psychiatrist or Treating Psychiatrist)
Date & Stamp: _____



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HOSPITAL _____ (name of hospital)

ECT TREATMENT SESSION FORM (ECT-SESSION form)

INSTRUCTIONS: (1) Please complete this ECT-SESSION form for each treatment session.
(2) ECT performed by ECT Medical Officer is to be supervised by ECT Administering Psychiatrist in the treatment area.

PATIENT'S NAME:		
RN / IC NO / AGE:	/ /	
GENDER:	<input type="checkbox"/> Male	<input type="checkbox"/> Female

SECTION 1: CURRENT ECT TREATMENT (to be completed by treating team)

ECT schedule	Treatment date	Treatment session number	Pre-ECT treatment status CGI Severity Scale
<input type="checkbox"/> Acute			<input type="checkbox"/> 0 – Not assessed
<input type="checkbox"/> Continuation / Maintenance			<input type="checkbox"/> 1 – Normal, not at all ill
Electrode placement	<input type="checkbox"/> Bilateral: <input type="checkbox"/> Temporal OR <input type="checkbox"/> Frontal		<input type="checkbox"/> 2 – Borderline mentally ill
Stimulus pulse width	<input type="checkbox"/> Unilateral: <input type="checkbox"/> Left OR <input type="checkbox"/> Right		<input type="checkbox"/> 3 – Mildly ill
Patient status	<input type="checkbox"/> Brief <input type="checkbox"/> Ultra-brief <input type="checkbox"/> Others: _____		<input type="checkbox"/> 4 – Moderately ill
Admission status	<input type="checkbox"/> Inpatient (Date of admission: _____)		<input type="checkbox"/> 5 – Markedly ill
Provision of consent	<input type="checkbox"/> Outpatient (Daycare)		<input type="checkbox"/> 6 – Severely ill
ECT treatment reviewed by	<input type="checkbox"/> Not applicable <input type="checkbox"/> Form 1 <input type="checkbox"/> Form 3 & Form 4		Medication regime change
	<input type="checkbox"/> Form 5 <input type="checkbox"/> Other(s): _____		<input type="checkbox"/> No
	<input type="checkbox"/> Patient		<input type="checkbox"/> Yes, please describe:
	<input type="checkbox"/> Relative / Guardian		
	<input type="checkbox"/> Two Psychiatrists		

(Signature & Name: ECT Prescribing Psychiatrist / Treating Psychiatrist / Treating Medical Officer)
Date & Stamp:

SECTION 2: PRE-ECT TREATMENT CHECKLIST (to be completed by ward / daycare staff in-charge)

Please check the following as stated:	CHECKED	Please check the following is done:	CHECKED
Patient fasted from 12 midnight		Personal hygiene attended	
Patient not smoking cigarettes at least past 24 hours		Patient in proper hospital attire	
Documents to accompany patient to treatment area:			
• Medical record / file (with any previous ECT-EEG tracings)		Hair dry & clean	
• Medication chart (check any pre-medication given & signed)		Face clean & makeup removed	
• Consent form: valid, completed & signed		Contact lenses & spectacles removed	
• ECT-PRESCRIBE form: completed & signed by psychiatrist in-charge		Hearing aids removed	
Pre-ECT observation in ward:			
Orientation: time, place, person <input type="checkbox"/> Yes <input type="checkbox"/> No		Dentures removed	
Temperature (°C):		Fingernails clean & nail polish removed	
Heart rate (bpm):		Jewellery removed	
Respiratory rate (BPM):		Patient encouraged to use the toilet	
Blood pressure (mmHg):			
SpO ₂ (%):			

Pre-ECT treatment checklist done by:

(Signature & Name: Staff In-charge)
Date & Stamp:



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SECTION 3: TIME OUT IN TREATMENT AREA

(to be performed by ECT Administering Psychiatrist / ECT Medical Officer, ECT Co-ordinator & Anaesthesia Provider; completed prior to general anaesthesia)

Pre-ECT treatment observation (by ECT Co-ordinator)

Date:	Time:	(Signature & Name: ECT Co-ordinator) Date & Stamp:
Orientation: time, place, person	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Temperature (°C):		
Heart rate (bpm):		
Respiratory rate (BPM):		
Blood pressure (mmHg):		
SpO ₂ (%):		

TIME-OUT ITEMS

<input type="checkbox"/> Correct patient <input type="checkbox"/> Dentures out <input type="checkbox"/> Bite block ready <input type="checkbox"/> Correct electrode placement (stimulus & recording) <input type="checkbox"/> Consent form valid, completed & signed <input type="checkbox"/> ECT-PRESCRIBE form completed & signed <input type="checkbox"/> Pre-ECT treatment observation done <input type="checkbox"/> Stimulus dose checked <input type="checkbox"/> Pulse width checked <input type="checkbox"/> Correct anaesthetic drugs (type & dose)	To proceed <input type="checkbox"/> YES <input type="checkbox"/> NO	_____ (Signature & Name: ECT Administering Psychiatrist / ECT Medical Officer) Date & Stamp: _____ (Signature & Name: ECT Co-ordinator) Date & Stamp: _____ (Signature & Name: Anaesthesia Provider) Date & Stamp:
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ECT-EEG QUALITY (based on NEURON ECT-EEG Algorithmic Rating Scale or NEARS)

- Recruitment : ≤ 5s prior to polyspike phase
- Amplitude : ≥ 1.5cm (3 boxes) & ≥ 10s in slow-wave complexes (bilateral)
- Symmetry : ≥ 50% from recruitment to slow-wave phase
- Duration : ≥ 15s from recruitment to termination phase
- Adequacy ≥ 50% or Post-ictal Suppression Index (PSI) ≥ 80%

1 st STIMULUS DOSE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> %	<input type="checkbox"/> Adequate (4-5 / 5) <input type="checkbox"/> Equivocal (3 / 5) <input type="checkbox"/> Inadequate (0-2 / 5)	2 nd STIMULUS DOSE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> %	<input type="checkbox"/> Adequate (4-5 / 5) <input type="checkbox"/> Equivocal (3 / 5) <input type="checkbox"/> Inadequate (0-2 / 5)
DURATION (s)		DURATION (s)	
Motor Seizure:		Motor Seizure:	
EEG Seizure:		EEG Seizure:	

3 rd STIMULUS DOSE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> %	<input type="checkbox"/> Adequate (4-5 / 5) <input type="checkbox"/> Equivocal (3 / 5) <input type="checkbox"/> Inadequate (0-2 / 5)	4 th STIMULUS DOSE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> %	<input type="checkbox"/> Adequate (4-5 / 5) <input type="checkbox"/> Equivocal (3 / 5) <input type="checkbox"/> Inadequate (0-2 / 5)
DURATION (s)		DURATION (s)	
Motor Seizure:		Motor Seizure:	
EEG Seizure:		EEG Seizure:	

Precaution or recommendation (e.g. post-ECT delirium, change in medication regime, stimulus dose for next treatment session):

ECT performed by:
(ECT performed by ECT Medical Officer is to be supervised by ECT Administering Psychiatrist in the treatment area)

 (Signature & Name: ECT Administering Psychiatrist / ECT Medical Officer)
 Date & Stamp:



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SECTION 4: POST-ECT RECOVERY

RECOVERY in ECT SUITE / OPERATING THEATRE

POST-ECT OBSERVATIONS (every 15 minutes or 2 minutes for Drowsy / Confused / Delirious state)	OBSERVATION 1 (immediate transfer in from treatment area)	OBSERVATION 2	OBSERVATION 3	OBSERVATION 4	Prior to transfer out to Ward / Daycare
Time					
State of consciousness	<input type="checkbox"/> Alert <input type="checkbox"/> Drowsy/ Confused/ Delirious <input type="checkbox"/> Unconscious	<input type="checkbox"/> Alert <input type="checkbox"/> Drowsy/ Confused/ Delirious <input type="checkbox"/> Unconscious	<input type="checkbox"/> Alert <input type="checkbox"/> Drowsy/ Confused/ Delirious <input type="checkbox"/> Unconscious	<input type="checkbox"/> Alert <input type="checkbox"/> Drowsy/ Confused/ Delirious <input type="checkbox"/> Unconscious	<input type="checkbox"/> Alert <input type="checkbox"/> Drowsy/ Confused/ Delirious <input type="checkbox"/> Unconscious
Temperature					
Heart rate					
Respiratory rate					
Blood pressure					
SpO ₂					
Time taken to regain consciousness (minutes)	Post-ECT recovery in ECT suite / Operating Theatre done by:		(Signature & Name: ECT Co-ordinator / Recovery Nurse) Date & Stamp:		
Issues / Intervention required (if any)					

RECOVERY in WARD / DAYCARE

POST-ECT OBSERVATIONS (to complete within 4 hours or more if required)
(½ hourly for first 2 hours then 1 hourly for next 2 hours)

Time						
State of consciousness	<input type="checkbox"/> Alert <input type="checkbox"/> Drowsy/ Confused/ Delirious <input type="checkbox"/> Unconscious	<input type="checkbox"/> Alert <input type="checkbox"/> Drowsy/ Confused/ Delirious <input type="checkbox"/> Unconscious	<input type="checkbox"/> Alert <input type="checkbox"/> Drowsy/ Confused/ Delirious <input type="checkbox"/> Unconscious	<input type="checkbox"/> Alert <input type="checkbox"/> Drowsy/ Confused/ Delirious <input type="checkbox"/> Unconscious	<input type="checkbox"/> Alert <input type="checkbox"/> Drowsy/ Confused/ Delirious <input type="checkbox"/> Unconscious	<input type="checkbox"/> Alert <input type="checkbox"/> Drowsy/ Confused/ Delirious <input type="checkbox"/> Unconscious
Orientation	<input type="checkbox"/> Time <input type="checkbox"/> Place <input type="checkbox"/> Person	<input type="checkbox"/> Time <input type="checkbox"/> Place <input type="checkbox"/> Person	<input type="checkbox"/> Time <input type="checkbox"/> Place <input type="checkbox"/> Person	<input type="checkbox"/> Time <input type="checkbox"/> Place <input type="checkbox"/> Person	<input type="checkbox"/> Time <input type="checkbox"/> Place <input type="checkbox"/> Person	<input type="checkbox"/> Time <input type="checkbox"/> Place <input type="checkbox"/> Person
Temperature						
Heart rate						
Respiratory rate						
Blood pressure						
SpO ₂						
Side effect(s) e.g. broken tooth, muscle ache	<input type="checkbox"/> Yes i.e. _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes i.e. _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes i.e. _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes i.e. _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes i.e. _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes i.e. _____ <input type="checkbox"/> No
Tolerated orally	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gait	<input type="checkbox"/> Stable <input type="checkbox"/> Unstable	<input type="checkbox"/> Stable <input type="checkbox"/> Unstable	<input type="checkbox"/> Stable <input type="checkbox"/> Unstable	<input type="checkbox"/> Stable <input type="checkbox"/> Unstable	<input type="checkbox"/> Stable <input type="checkbox"/> Unstable	<input type="checkbox"/> Stable <input type="checkbox"/> Unstable
Stable to cease observation	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cannula removed	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comments (if any):	Post-ECT recovery in ward / daycare done by:		(Signature & Name: Staff In-charge) Date & Stamp:			