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

PATIENT'S CONSENT FORM FOR ELECTROCONVULSIVE THERAPY (ECT)

I, _____

I.C. No.: _____ hereby consent to undergo a course of Electroconvulsive Therapy (ECT) in _____ (name of hospital) as follows:

☐ **ACUTE** phase: from _____ (date of first treatment session) to _____ (date of last treatment session) for a period of up to four (4) weeks at a treatment interval of 2 or 3 sessions per week.

OR

☐ **CONTINUATION** or **MAINTENANCE** phase: from _____ (date of first treatment session) to _____ (date of last treatment session) for a period of up to four (4) weeks at a treatment interval determined by the ECT Prescribing Psychiatrist.

Dr. _____ has explained that I have the following condition: _____ (principal diagnosis to be treated by ECT), and that:

1. The doctor has recommended Electroconvulsive Therapy (ECT) to be an appropriate treatment for my condition.
2. The doctor has explained ECT and why it is an appropriate treatment for my condition. The explanation has included information about the expected benefits of ECT and the likely consequences if I do not have ECT.
3. The doctor has explained the likely discomforts and risks associated with ECT.
4. The doctor has informed me of the benefits and risks of other alternative treatment(s).
5. I understand that I will have a general anaesthesia and muscle relaxant administered before being given ECT.
6. I have been given the ECT Information Sheet and explained on it by the doctor.
7. I have been given the opportunity to ask questions about ECT and my condition, and I have understood the answers.
8. I understand that I am free to refuse ECT or to withdraw my consent and have the ECT stopped at any time.
9. I understand that an assurance has not been given that the treatment will be administered by a specific practitioner; however, it will be administered by a privileged practitioner in ECT from _____ _____ (name of hospital).

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

PATIENT'S CONSENT FORM FOR ELECTROCONVULSIVE THERAPY (ECT)

Patient's statement

I, the abovenamed patient: _____

I.C. No.: _____ consent to being treated with ECT.

This consent is valid from the day I sign this consent form for **ACUTE** OR **CONTINUATION** or **MAINTENANCE** ECT (delete whichever is not applicable) from _____ to _____ for a period of up to four (4) weeks.

I've also read and understood the ECT Information Sheet as provided.

Signature: _____ Date: _____

Witness' statement

I, _____ (name of witness) bear witness to the process of obtaining informed consent on ECT from the abovenamed patient.

The patient signed this consent form voluntarily in my presence.

(The witness should be a fully registered medical practitioner or staff nurse or assistant medical officer, who is not directly involved in the management of the abovenamed patient nor related to the patient, to attest to the consent-taking process from the patient).

Signature & official stamp: _____ Date: _____

ECT Prescribing Psychiatrist's statement

I, Dr. _____ hereby certify that I am the ECT Prescribing Psychiatrist for the abovenamed patient.

I am of the opinion that ECT is an appropriate treatment for the abovenamed patient. The patient has understood the above explanation on ECT and is capable of giving informed consent to the proposed course of ECT. This consent form is complete and correctly filled in.

Signature & official stamp: _____ Date: _____

KEMENTERIAN KESIHATAN MALAYSIA
JABATAN PSIKIATRI DAN KESIHATAN MENTAL
HOSPITAL _____ **(nama hospital)**

BORANG KEIZINAN PESAKIT MENJALANI TERAPI ELEKTROKONVULSIF (ECT)

Saya, _____

No. K/P: _____ dengan ini memberi keizinan untuk menjalani Terapi Elektrokonvulsif (ECT) di _____ (nama hospital) seperti yang tertera:

☐ Fasa ***ACUTE***: dari _____ (tarikh sesi rawatan pertama) hingga _____ (tarikh sesi rawatan terakhir) untuk tempoh sehingga empat (4) minggu pada selang waktu rawatan 2 atau 3 sesi seminggu.

ATAU

☐ Fasa ***CONTINUATION*** atau ***MAINTENANCE***: dari _____ (tarikh sesi rawatan pertama) hingga _____ (tarikh sesi rawatan terakhir) untuk tempoh sehingga empat (4) minggu pada selang waktu rawatan yang ditetapkan oleh pakar psikiatri yang mempreskripsi ECT.

Dr. _____ telah menerangkan bahawa saya menghidapi penyakit berikut: _____ (diagnosis utama yang perlu dirawat menggunakan ECT) dan:

1. Doktor telah menyarankan Terapi Elektrokonvulsif (ECT) merupakan rawatan yang wajar untuk keadaan penyakit saya ini.
2. Doktor telah menerangkan tentang ECT dan mengapa rawatan ini wajar bagi merawat keadaan penyakit saya. Penerangan doktor telah meliputi manfaat yang dijangka akan diperolehi oleh saya jika menjalani ECT dan akibatnya jika tidak menjalani ECT.
3. Doktor telah menerangkan tentang kemungkinan saya akan mengalami ketidakselesaan dan risiko-risiko berkaitan ECT.
4. Doktor telah memberitahu saya tentang manfaat dan risiko pilihan rawatan lain.
5. Saya memahami bahawa ubat bius dan penenang otot akan diberikan kepada saya sebelum ECT dimulakan.
6. Saya telah diberi Lembaran Maklumat ECT berserta penerangannya oleh doktor.
7. Saya telah diberi peluang untuk bertanya tentang ECT serta keadaan penyakit saya dan saya telah memahami penerangan yang diberikan.
8. Saya memahami bahawa saya bebas untuk tidak bersetuju menjalani ECT atau menarik semula keizinan saya dan berhenti menjalani ECT pada bila-bila masa.
9. Saya memahami tiada jaminan bahawa ECT akan dijalankan oleh pengamal yang tertentu; walau bagaimanapun, rawatan ini akan dijalankan oleh pengamal yang diberi hak keistimewaan untuk rawatan ECT di _____ (nama hospital).

KEMENTERIAN KESIHATAN MALAYSIA
JABATAN PSIKIATRI DAN KESIHATAN MENTAL
HOSPITAL _____ (nama hospital)

BORANG KEIZINAN PESAKIT MENJALANI TERAPI ELEKTROKONVULSIF (ECT)

Kenyataan Pesakit

Saya, pesakit bernama seperti di atas _____

No. K/P: _____ dengan ini memberi keizinan untuk menjalani rawatan ECT.

Keizinan ini sah bermula daripada tarikh borang keizinan ini ditandatangani untuk ***ACUTE*** ATAU ***CONTINUATION*** atau ***MAINTENANCE*** ECT (potong yang mana tidak berkenaan) dari _____ hingga _____ untuk tempoh sehingga empat (4) minggu.

Saya juga telah membaca dan memahami Lembaran Maklumat ECT yang disediakan.

Tandatangan: _____ Tarikh: _____

Kenyataan Saksi

Saya, _____ (nama saksi) telah menyaksikan proses pengambilan keizinan termaklum berkenaan ECT daripada pesakit bernama seperti di atas.

Pesakit telah menandatangani borang keizinan ini secara sukarela di hadapan saya.

(Saksi mestilah merupakan seorang pengamal perubatan atau jururawat atau pembantu pegawai perubatan yang mempunyai pendaftaran penuh, tidak terlibat secara langsung dalam perawatan pesakit, dan tidak mempunyai hubungan dengan pesakit, bagi tujuan memperakui proses pengambilan keizinan daripada pesakit).

Tandatangan dan cap rasmi: _____ Tarikh: _____

Kenyataan Pakar Psikiatri Yang Mempreskripsi ECT

Saya, Dr. _____ memperakui bahawa saya adalah pakar psikiatri yang mempreskripsi ECT untuk pesakit bernama seperti di atas.

Saya berpendapat bahawa ECT merupakan rawatan yang wajar untuk pesakit bernama seperti di atas. Pesakit telah memahami penerangan berkenaan ECT di atas dan berkebolehan memberi keizinan termaklum untuk menjalani rawatan ECT seperti yang telah dibincangkan. Borang keizinan ini adalah lengkap dan diisi dengan betul.

Tandatangan dan cap rasmi: _____ Tarikh: _____

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

RELATIVE'S / GUARDIAN'S CONSENT FORM FOR ELECTROCONVULSIVE THERAPY (ECT)

I, _____

I.C. No.: _____ being the _____ (state nature of relationship) of _____ (patient's name), (patient's I.C. No.: _____) hereby consent the patient to undergo a course of Electroconvulsive Therapy (ECT) in _____ (name of hospital) as follows:

☐ **ACUTE** phase: from _____ (date of first treatment session) to _____ (date of last treatment session) for a period of up to four (4) weeks at a treatment interval of 2 or 3 sessions per week.

OR

☐ **CONTINUATION** or **MAINTENANCE** phase: from _____ (date of first treatment session) to _____ (date of last treatment session) for a period of up to four (4) weeks at a treatment interval determined by the ECT Prescribing Psychiatrist.

Dr. _____ has explained that the patient has the following condition: _____ (principal diagnosis to be treated by ECT), and that:

1. The doctor has recommended Electroconvulsive Therapy (ECT) to be an appropriate treatment for the patient's condition.
2. The doctor has explained ECT and why it is an appropriate treatment for the patient's condition. The explanation has included information about the expected benefits of ECT and the likely consequences if the patient does not have ECT.
3. The doctor has explained the likely discomforts and risks associated with ECT.
4. The doctor has informed me of the benefits and risks of other alternative treatment(s).
5. I understand that the patient will have a general anaesthesia and muscle relaxant administered before being given ECT.
6. I have been given the ECT Information Sheet and explained on it by the doctor.
7. I have been given the opportunity to ask questions about ECT and the patient's condition, and I have understood the answers.
8. I understand that I am free to refuse ECT for the patient or to withdraw my consent and have the ECT stopped at any time.
9. I understand that an assurance has not been given that the treatment will be administered by a specific practitioner; however, it will be administered by a privileged practitioner in ECT from _____ _____ (name of hospital).

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

RELATIVE'S / GUARDIAN'S CONSENT FORM FOR ELECTROCONVULSIVE THERAPY (ECT)

Relative's / Guardian's statement

I am the _____ (state nature of relationship) of the abovenamed patient.

I consent _____ (patient's name),
(patient's I.C. No.: _____) to being treated with ECT.

This consent is valid from the day I sign this consent form for **ACUTE** OR **CONTINUATION** or **MAINTENANCE** ECT (delete whichever is not applicable) from _____ to _____ for a period of up to four (4) weeks.

I've also read and understood the ECT Information Sheet as provided.

Signature: _____ Date: _____

Witness' statement

I, _____ (name of witness) bear witness to the process of obtaining informed consent on ECT from the abovenamed relative / guardian.

The relative / guardian signed this consent form voluntarily in my presence.

(The witness should be a fully registered medical practitioner or staff nurse or assistant medical officer, who is not directly involved in the management of the abovenamed patient nor related to the patient, to attest to the consent-taking process from the relative / guardian).

Signature & official stamp: _____ Date: _____

ECT Prescribing Psychiatrist's statement

I, Dr. _____
hereby certify that I am the ECT Prescribing Psychiatrist for the abovenamed patient.

I am of the opinion that ECT is an appropriate treatment for the abovenamed patient. The relative / guardian has understood the above explanation on ECT and agrees to give informed consent for the patient to undergo the proposed course of ECT. This consent form is complete and correctly filled in.

Signature & official stamp: _____ Date: _____

KEMENTERIAN KESIHATAN MALAYSIA
JABATAN PSIKIATRI DAN KESIHATAN MENTAL
HOSPITAL _____ **(nama hospital)**

BORANG KEIZINAN SAUDARA / PENJAGA BAGI PESAKIT MENJALANI TERAPI ELEKTROKONVULSIF (ECT)

Saya, _____

No. K/P: _____ yang merupakan _____

(nyatakan hubungan dengan pesakit) kepada pesakit bernama _____

_____ (nama pesakit), (No. K/P pesakit: _____) dengan ini memberi keizinan untuk pesakit menjalani Terapi Elektrokonvulsif (ECT) di _____ (nama hospital) seperti yang tertera:

☐ Fasa ***ACUTE***: dari _____ (tarikh sesi rawatan pertama) hingga _____ (tarikh sesi rawatan terakhir) untuk tempoh sehingga empat (4) minggu pada selang waktu rawatan 2 atau 3 sesi seminggu.

ATAU

☐ Fasa ***CONTINUATION*** atau ***MAINTENANCE***: dari _____ (tarikh sesi rawatan pertama) hingga _____ (tarikh sesi rawatan terakhir) untuk tempoh sehingga empat (4) minggu pada selang waktu rawatan yang ditetapkan oleh pakar psikiatri yang mempreskripsi ECT.

Dr. _____ telah menerangkan bahawa pesakit menghidapi penyakit berikut: _____

(diagnosis utama yang perlu dirawat menggunakan ECT), dan:

1. Doktor telah menyarankan Terapi Elektrokonvulsif (ECT) merupakan rawatan yang wajar untuk keadaan penyakit pesakit ini.
2. Doktor telah menerangkan tentang ECT dan mengapa rawatan ini wajar bagi merawat keadaan penyakit pesakit. Penerangan doktor telah meliputi manfaat yang dijangka akan diperolehi oleh pesakit jika menjalani ECT dan akibatnya jika tidak menjalani ECT.
3. Doktor telah menerangkan tentang kemungkinan pesakit akan mengalami ketidakselesaan dan risiko-risiko berkaitan ECT.
4. Doktor telah memberitahu saya tentang manfaat dan risiko pilihan rawatan lain.
5. Saya memahami bahawa ubat bius dan penenang otot akan diberikan kepada pesakit sebelum ECT dimulakan.
6. Saya telah diberi Lembaran Maklumat ECT berserta penerangannya oleh doktor.
7. Saya telah diberi peluang untuk bertanya tentang ECT serta keadaan penyakit pesakit dan saya telah memahami penerangan yang diberikan.
8. Saya memahami bahawa saya bebas untuk tidak bersetuju pesakit menjalani ECT atau menarik semula keizinan saya dan pesakit berhenti menjalani ECT pada bila-bila masa.
9. Saya memahami tiada jaminan bahawa ECT akan dijalankan oleh pengamal yang tertentu; walau bagaimanapun, rawatan ini akan dijalankan oleh pengamal yang diberi hak keistimewaan untuk rawatan ECT di _____ (nama hospital).

KEMENTERIAN KESIHATAN MALAYSIA
JABATAN PSIKIATRI DAN KESIHATAN MENTAL
HOSPITAL _____ **(nama hospital)**

BORANG KEIZINAN SAUDARA / PENJAGA BAGI PESAKIT MENJALANI TERAPI ELEKTROKONVULSIF (ECT)

Kenyataan Saudara / Penjaga Pesakit

Saya, _____ (nyatakan hubungan dengan pesakit) kepada pesakit yang bernama seperti di atas.

Saya memberi keizinan ke atas _____ (nama pesakit), (No. K/P pesakit: _____) untuk menjalani rawatan ECT.

Keizinan ini sah bermula daripada tarikh borang keizinan ini ditandatangani untuk ***ACUTE*** ATAU ***CONTINUATION*** atau ***MAINTENANCE*** ECT (potong yang mana tidak berkenaan) dari _____ hingga _____ untuk tempoh sehingga empat (4) minggu.

Saya juga telah membaca dan memahami Lembaran Maklumat ECT yang disediakan.

Tandatangan: _____ Tarikh: _____

Kenyataan Saksi

Saya, _____ (nama saksi) telah menyaksikan proses pengambilan keizinan termaklum berkenaan ECT daripada saudara / penjaga pesakit bernama seperti di atas.

Saudara / Penjaga pesakit telah menandatangani borang keizinan ini secara sukarela di hadapan saya.

(Saksi mestilah merupakan seorang pengamal perubatan atau jururawat atau pembantu pegawai perubatan yang mempunyai pendaftaran penuh, tidak terlibat secara langsung dalam perawatan pesakit, dan tidak mempunyai hubungan dengan pesakit, bagi tujuan memperakui proses pengambilan keizinan daripada saudara / penjaga pesakit).

Tandatangan dan cap rasmi: _____ Tarikh: _____

Kenyataan Pakar Psikiatri Yang Mempreskripsi ECT

Saya, Dr. _____ memperakui bahawa saya adalah pakar psikiatri yang mempreskripsi ECT untuk pesakit bernama seperti di atas.

Saya berpendapat bahawa ECT merupakan rawatan yang wajar untuk pesakit bernama seperti di atas. Saudara / Penjaga pesakit telah memahami penerangan berkenaan ECT di atas dan menyetujui memberi keizinan termaklum untuk pesakit menjalani rawatan ECT seperti yang telah dibincangkan. Borang keizinan ini adalah lengkap dan diisi dengan betul.

Tandatangan dan cap rasmi: _____ Tarikh: _____

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

CONSENT BY TWO PSYCHIATRISTS* FOR ELECTROCONVULSIVE THERAPY (ECT)

ECT Prescribing Psychiatrist:

I, Dr. _____ (name of registered psychiatrist), from _____ (name of hospital), hereby certify that I am the ECT Prescribing Psychiatrist responsible for treating _____ (name of patient) _____ (I.C. No.) at the abovenamed hospital.

1. The abovenamed patient has the following psychiatric illness for which I consider Electroconvulsive Therapy (ECT) to be an appropriate treatment: _____ (principal diagnosis to be treated by ECT).
2. I am satisfied that:
   a. The patient is incapable of giving informed consent for ECT.
   b. ECT has therapeutic effects and is an appropriate treatment for the patient's psychiatric illness.
   c. ECT should be performed after weighing the discomforts, benefits or risks.
   d. Any benefits and risks of other alternative treatment(s) have been considered.
   e. Unless ECT is performed, the patient is likely to suffer a significant deterioration in his or her physical or psychiatric condition.
3. I therefore authorize ECT to be performed on the abovenamed patient.
4. The reasons for my decision are: _____
   _____
5. This authority is for:

☐ **ACUTE** phase: from _____ (date of first treatment session) to _____ (date of last treatment session) for a period of up to four (4) weeks at a treatment interval of 2 or 3 sessions per week.

OR

☐ **CONTINUATION** or **MAINTENANCE** phase: from _____ (date of first treatment session) to _____ (date of last treatment session) for a period of up to four (4) weeks at a treatment interval determined by the ECT Prescribing Psychiatrist.

I am the ECT Prescribing Psychiatrist responsible for treating the abovenamed patient. The patient's treatment plan has been reviewed, revised and discussed with the patient, to the best of his or her understanding.

Signature & official stamp: _____ Date: _____

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

CONSENT BY TWO PSYCHIATRISTS* FOR ELECTROCONVULSIVE THERAPY (ECT)

Independent ECT Prescribing Psychiatrist:

I, Dr. _____ (name of registered psychiatrist), from _____ (name of hospital), hereby certify that I am the independent ECT Prescribing Psychiatrist for _____ (name of patient) _____ (I.C. No.) at the abovenamed hospital.

1. The abovenamed patient has the following psychiatric illness for which I consider Electroconvulsive Therapy (ECT) to be an appropriate treatment: _____ (principal diagnosis to be treated by ECT).
2. I am satisfied that:
   a. The patient is incapable of giving informed consent for ECT.
   b. ECT has therapeutic effects and is an appropriate treatment for the patient's psychiatric illness.
   c. ECT should be performed after weighing the discomforts, benefits or risks.
   d. Any benefits and risks of other alternative treatment(s) have been considered.
   e. Unless ECT is performed, the patient is likely to suffer a significant deterioration in his or her physical or psychiatric condition.
3. I therefore authorize ECT to be performed on the abovenamed patient.
4. The reasons for my decision are: _____
5. This authority is for:

☐ **ACUTE** phase: from _____ (date of first treatment session) to _____ (date of last treatment session) for a period of up to four (4) weeks at a treatment interval of 2 or 3 sessions per week.

OR

☐ **CONTINUATION** or **MAINTENANCE** phase: from _____ (date of first treatment session) to _____ (date of last treatment session) for a period of up to four (4) weeks at a treatment interval determined by the ECT Prescribing Psychiatrist.

I am the independent ECT Prescribing Psychiatrist. The patient's treatment plan has been reviewed, revised and discussed with the patient, to the best of his or her understanding.

Signature & official stamp: _____ Date: _____

***one of whom shall be the ECT Prescribing Psychiatrist responsible for treating the patient, if no relative or guardian of the patient is available or traceable and the patient himself or herself is incapable of giving consent.**

ANAESTHESIA DISCLOSURE AND CONSENT

Ministry Of Health Malaysia

Patient Details

Name .....

I/C No. .....

Gender .....

Address .....

.....

RN .....

Name Of Surgery/Procedure .....

.....

Parent / Guardian

Name .....

I/C No. .....

Anaesthetists stress on safety during anaesthesia and endeavour to prevent any complications arising from anaesthesia.
Anaesthesia affects the patient's breathing and circulation, while the operation itself also causes changes to the patient's body. The anaesthetist uses special skills and equipment to monitor and manage the patient to ensure their safety during anaesthesia and the operation. Death or permanent disability related to anaesthesia is rare.

General Anaesthesia

Involves rendering a patient unconscious before an operation. This ensures the patient is not aware of events and does not feel pain during the operation. It is produced by drugs given through a vein and/or breathed from an anaesthesia machine.

Regional Anaesthesia

Involves using a local anaesthetic to numb a specific area of the body for surgery. Prolonged pain relief without numbness can be achieved by infusing weak solutions of local anaesthetics and narcotic drugs to particular parts of the body after surgery or injury.

Risks

Common risks for ALL patients include :-

- Bruising at the site of injections or intravenous line
- Nausea or vomiting
- Sore throat from the gases and/or the breathing tube. You may notice temporary difficulty in speaking. This should improve after some hours
- Temporary muscle pains
- Temporary headache or blurred vision

Uncommon risks for ALL patients include :-

- Awareness of activity in the operating room during anaesthesia, particularly during certain operations and in some emergency situations
- Eye abrasions causing pain and requiring treatment with medication and patching
- Damage to teeth or dental work, lips or tongue

Extremely rare risks for ALL patients. These may cause brain damage or death and include :-

- Obstructions in the breathing passages that cannot be readily controlled. These can lead to severe difficulty with breathing
- Allergy to drugs causing wheezing and rash and in rare cases, severe swelling, low blood pressure and poor circulation
- Inherited muscle sensitivity to particular anaesthetic drugs (malignant hyperthermia). This can cause a rapid rise in temperature, heart rate and breathing with high blood pressure and muscle rigidity
- Heart attacks, strokes and pneumonia. While these are uncommon, the risks are higher for patients with diseases of the arteries or lungs and in smokers.

Risks

Common :-

- Muscle weakness in the anaesthetised limb, or difficulty passing urine for a lower body block, while the anaesthetic is working. While this returns to normal as the drugs' effect wear off, a temporary urinary catheter may be necessary
- Headache, which is usually short-lived but can be severe and last some days

Uncommon :-

- Damage the nearby blood vessels or organs eg lungs
- Backache may follow spinal or epidural anaesthesia. This usually improves quickly, but occasionally can be lasting
- There is a very small risk of infection or bleeding at the injection site, which may require antibiotic or surgical treatment

Extremely rare :-

- Rarely, nerves may be damaged resulting in long-term weakness, pain, altered sensation or paralysis

Note **

There may be other unusual risks that have not been listed here. Please ask your anaesthetist if you have any general or specific concerns.

RISK CONTINUED OVER ⟶

INDIVIDUAL RISKS (to be completed by the anaesthetist completing this form)

The following are examples of possible risks and complications specific to this patient:

.....

.....

.....

.....

.....

.....

DECLARATION BY PATIENT / GUARDIAN / PROXY

- I acknowledge the anaesthetist has informed me about the anaesthetic procedure, alternative treatments and answered my specific queries and concerns about this matter. I understand that a different anaesthetist may give the anaesthetic.
- I acknowledge that I have discussed with the anaesthetist significant risks and complications specific to my individual circumstances that I have considered in deciding to undergo anaesthesia.

Signature of patient ..... **I/C No.** .....

Print name ..... **Date** .....

Signature of person consenting if not the patient ..... **I/C No** .....

Print name ..... **Relation** .....

Date .....

DECLARATION BY THE ANAESTHETIST PROVIDING INFORMATION FOR THIS CONSENT

- I declare that I have explained the nature of general and/or regional anaesthesia to be given and discussed the risks that particularly concern this patient.
- I have given the patient an opportunity to ask questions and I have answered accordingly.

Doctor's signature ..... **I/C No** .....

Print name ..... **Date** .....

Signature of witness ..... **I/C No** .....

Print name ..... **Date** .....

REEXPLAINATION .....

.....

Doctor's signature ..... **I/C No.** .....

Print name ..... **Date** .....

Signature of witness ..... **I/C No.** .....

Print name ..... **Date** .....

BORANG PENERANGAN DAN KEIZINAN ANESTESIA

Kementerian Kesihatan Malaysia

Maklumat Pesakit

Nama .....

No. K/P .....

Jantina .....

Alamat .....

.....

No. Daftar /RN .....

Nama Pembedahan/Prosedur .....

.....

Ibubapa/Penjaga

Nama .....

No. K/P .....

Pembiusan memberi kesan terhadap pernafasan dan peredaran darah pesakit manakala pembedahan membawa perubahan kepada tubuh pesakit. Doktor Anestesiologi menggunakan kepakaran dan peralatan khusus untuk memantau dan mengurus pesakit bagi memastikan keselamatan pesakit semasa pembiusan dan pembedahan.
doktor Anestesiologi sentiasa menekankan tentang keselamatan semasa pembiusan. Kematian atau kecederaan kekal amat jarang berlaku.

Pembiusan Umum :
Menjadikan seseorang pesakit berada dalam keadaan tidak sedar sebelum pembedahan dimulakan. Ini bagi memastikan pesakit tidak menyedari apa yang berlaku dan tidak merasa sakit semasa pembedahan. Pembiusan umum dilakukan dengan memasukkan ubat bius ke dalam salur darah dan/atau melalui gas bius yang disedut dari mesin bius. Tiub pernafasan akan dimasukkan ke dalam mulut atau hidung pesakit untuk membantunya bernafas dengan mesin.

Pembiusan Setempat :
Melibatkan penggunaan ubat bius setempat untuk melalikan bahagian badan tertentu yang akan dibedah. Pesakit sedar tetapi tidak merasa apa-apa sewaktu pembedahan. Kelegaan sakit tanpa kebas boleh di lanjutkan selepas pembedahan atau kecederaan dengan menggunakan ubat bius setempat yang tidak begitu kuat yang telah di campurkan dengan ubat narkotik.

Risiko Pembiusan Umum

Risiko yang biasa terjadi :-

- Kesan lebam di tempat suntikan atau pemasangan tiub aliran darah
- Loya atau muntah
- Sakit tekak disebabkan oleh gas pembiusan dan/atau tiub pernafasan. Pesakit akan mungkin mengalami kesukaran bercakap tetapi ini akan pulih seperti sediakala dalam masa beberapa jam
- Kesakitan otot yang sementara
- Sakit kepala atau kabur penglihatan buat sementara

Risiko yang mungkin tetapi jarang berlaku :-

- Menyedari aktiviti yang berlaku di dewan bedah ketika di bawah pembiusan umum terutama semasa pembedahan tertentu dan dalam beberapa situasi kecemasan
- Luka di mata yang menyebabkan kesakitan dan mungkin memerlukan rawatan
- Kecederaan kepada gigi, gusi, bibir dan lidah

Risiko yang sangat jarang sekali berlaku tetapi mungkin boleh mengakibatkan kerosakkan otak atau kematian :-

- Saluran pernafasan tersumbat dan tidak dapat dikawal menyebabkan pesakit sukar untuk bernafas
- Alahan terhadap ubat yang boleh menyebabkan kesesakan nafas dan ruam dan kadang-kadang bengkak yang teruk, tekanan darah yang menurun dan peredaran darah menjadi lemah
- Otot yang sensitif terhadap ubat bius tertentu (malignant hyperthermia). Ini akan menyebabkan suhu badan, degupan jantung, tekanan darah dan kadar pernafasan meningkat naik secara mendadak dan otot menjadi kejang
- Serangan jantung, angin ahmar dan jangkitan paru-paru walaupun jarang berlaku, tetapi risikonya adalah lebih tinggi di kalangan pesakit yang mempunyai penyakit salur darah atau paru-paru dan penghisap rokok

Risiko Pembiusan Setempat

Risiko yang biasa terjadi :-

- Kelemahan otot di bahagian anggota badan yang dibius. Bagi kes yang melibatkan pembiusan di bahagian bawah badan, kesukaran kencing mungkin dialami sewaktu kesan bius masih berjalan. Walaupun ini akan beransur pulih seperti biasa apabila kesan ubat bius habis, tetapi pesakit mungkin memerlukan bantuan tiub saluran kencing buat sementara waktu
- Sakit kepala yang kebiasaannya akan baik dalam tempoh yang singkat tetapi boleh juga bertambah teruk dan berterusan selama beberapa hari

Risiko yang mungkin tetapi jarang berlaku :-

- Kerosakan kepada salur darah dan organ yang berdekatan, seperti paru-paru
- Sakit belakang mungkin dialami selepas pembiusan 'spinal' atau epidural. Kebiasaannya, ia akan baik dengan sendiri tetapi boleh juga berterusan untuk tempoh yang agak lama
- Terdapat juga risiko kecil berlakunya jangkitan kuman atau pendarahan di tempat suntikan yang mungkin memerlukan rawatan antibiotik atau pembedahan

Risiko yang sangat jarang berlaku :-

- Kerosakan urat saraf, walaupun jarang-jarang berlaku boleh mengakibatkan kelemahan anggota badan, sakit, gangguan sensasi atau lumpuh untuk tempoh yang berpanjangan

Nota **

Risiko-risiko lain yang agak luar biasa tidak di senaraikan di sini. Sila rujuk kepada pakar anestesiologi yang berkenaan sekiranya terdapat persoalan samada yang umum ataupun khusus.

LIHAT SEBELAH ⟶

RISIKO-RISIKO INDIVIDU (untuk diisi oleh Pegawai Perubatan/Pakar Anestesiologi)

Berikut adalah contoh-contoh risiko yang kemungkinan berlaku & komplikasi khusus terhadap pesakit ini :

.....

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PENGAKUAN OLEH PESAKIT / PENJAGA / WAKIL

- Saya mengaku bahawasanya doktor Anestesiologi telah memaklumkan kepada saya mengenai prosedur pembiusan, rawatan alternatif dan menjawab semua persoalan & kemusykilan saya. Saya faham bahawa ada kemungkinan doktor Anestesiologi yang berbeza akan membius saya pada hari pembedahan.
- Saya mengaku bahawasanya saya telah berbincang dengan doktor Anestesiologi mengenai risiko-risiko penting dan komplikasi khusus yang berkait rapat dengan saya dan saya telah memutuskan untuk menjalani pembiusan .

Tandatangan Pesakit ..... **No. K/P** .....

Nama (Huruf Besar) ..... **Tarikh** .....

Sekiranya penjaga / wakil yang memberi kebenaran

Tandatangan Penjaga / Wakil ..... **No. K/P** .....

Nama (Huruf Besar) ..... **Hubungan** .....

Tarikh .....

PENGAKUAN DOKTOR ANESTESIOLOGI YANG BERKENAAN

- Saya mengaku bahawa saya telah menerangkan ciri-ciri pembiusan umum atau setempat yang akan diberikan dan telah membincangkan mengenai risiko-risiko yang mungkin dialami oleh pesakit. .
- Saya telah memberi peluang kepada pesakit untuk bertanya dan telah menjawab soalan-soalan yang dikemukakan.

Tandatangan Doktor ..... **No. K/P** .....

Nama (Huruf Besar) ..... **Tarikh** .....

Tandatangan Saksi / Penterjemah ..... **No. K/P** .....

Nama (Huruf Besar) ..... **Tarikh** .....

PENERANGAN SEMULA .....

.....

Tandatangan Doktor ..... **No. K/P** .....

Nama (Huruf Besar) ..... **Tarikh** .....

Tandatangan Saksi / Penterjemah ..... **No. K/P** .....

Nama (Huruf Besar) ..... **Tarikh** .....

BORANG PENERANGAN DAN KEIZINAN ANESTESIA

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:	☐ Male ☐ Female

SECTION 1: CURRENT ECT COURSE

☐ **ACUTE** phase: From (Date of first treatment session) _____ to (Date of last treatment session) _____ for a period of up to four (4) weeks at a treatment interval of 2 or 3 sessions per week.

OR

☐ **CONTINUATION or MAINTENANCE** phase: From (Date of first treatment session) _____ to (Date of last treatment session) _____ for a period of up to four (4) weeks at a treatment interval determined by the ECT Prescribing Psychiatrist.

Principal indication(s) for ECT prescription

☐ Rapid definitive response is needed
☐ Previous good response to ECT
☐ Patient's preference
☐ Risks of other alternative treatment(s) outweigh risks of ECT
☐ Actively suicidal / Life-threatening situation
☐ Other(s): _____

Psychiatric diagnosis (based on DSM-5)

☐ Schizophrenia Spectrum & Other Psychotic Disorders
Specify: _____
☐ Bipolar & Related Disorders
Specify: _____
☐ Depressive Disorders
Specify: _____
☐ Obsessive-Compulsive & Related Disorders
Specify: _____
☐ Others
Specify: _____

Patient status

☐ Inpatient
(Date of admission: _____)
☐ Outpatient (Daycare)

Admission status

☐ Not applicable
☐ Form 1
☐ Form 3 & Form 4
☐ Form 5
☐ Other(s): _____

Provision of consent

☐ Patient
☐ Relative / Guardian
☐ Two Psychiatrists

Read & understood ECT Information Sheet

☐ Yes
☐ No, state reason: _____

Electrode placement

☐ Bilateral: ☐ Temporal **OR** ☐ Frontal
☐ Unilateral: ☐ Left **OR** ☐ Right

Stimulus pulse width

☐ Brief ☐ Ultra-brief
☐ Others: _____

Handedness

☐ Left ☐ Right

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

ECT PRESCRIPTION & REVIEW FORM (ECT-PRESCRIBE form)

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
☐ 1 – Very much improved
☐ 2 – Much improved
☐ 3 – Minimally improved
☐ 4 – No change
☐ 5 – Minimally worse
☐ 6 – Much worse
☐ 7 – Very much worse

SECTION 3: MEDICAL REVIEW

Past medical history

Current medication(s)

Smoker ☐ Yes ☐ No

Pre-ECT systems review (√ if present)

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

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

Investigations (Summary of results)

Results	Findings
Full blood count Date: _____	☐ Normal ☐ Abnormal, please specify: ☐ Not done, reason:
Renal profile Date: _____	☐ Normal ☐ Abnormal, please specify: ☐ Not done, reason:
Chest X-Ray Date: _____	☐ Normal ☐ Abnormal, please specify: ☐ Not done, reason:
Electrocardiogram Date: _____	☐ Normal ☐ Abnormal, please specify: ☐ Not done, reason:

Physical examination (Date: _____)

Height:	_____ m
Weight:	_____ kg
Temperature:	_____ ^{0}C
Heart rate:	_____ bpm
Respiratory rate:	_____ BPM
Blood pressure:	_____ mmHg
SpO_2:	_____ %
Skull defect:	☐ Yes ☐ No
(if Yes, with metal implant):	☐ Yes ☐ No
Cochlear implant:	☐ Yes ☐ No
Dentures:	☐ Yes ☐ No
CIED (Cardiac implantable electronic device):	☐ Yes ☐ No
Examination findings:	☐ Normal ☐ Abnormal If abnormal, please describe:

ECT-PRESCRIBE form reviewed by:

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

MINISTRY OF HEALTH, MALAYSIA
DEPARTMENT OF PSYCHIATRY & MENTAL HEALTH
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:	☐ Male ☐ Female

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

ECT schedule	Treatment date	Treatment session number
☐ Acute		
☐ Continuation / Maintenance		

Electrode placement	☐ Bilateral: ☐ Temporal **OR** ☐ Frontal ☐ Unilateral: ☐ Left **OR** ☐ Right
Stimulus pulse width	☐ Brief ☐ Ultra-brief ☐ Others: ____
Patient status	☐ Inpatient (Date of admission: ____) ☐ Outpatient (Daycare)
Admission status	☐ Not applicable ☐ Form 1 ☐ Form 3 & Form 4 ☐ Form 5 ☐ Other(s): ____
Provision of consent	☐ Patient ☐ Relative / Guardian ☐ Two Psychiatrists

Pre-ECT treatment status
CGI Severity Scale
- ☐ 0 – Not assessed
- ☐ 1 – Normal, not at all ill
- ☐ 2 – Borderline mentally ill
- ☐ 3 – Mildly ill
- ☐ 4 – Moderately ill
- ☐ 5 – Markedly ill
- ☐ 6 – Severely ill
- ☐ 7 – Among the most extremely ill

Medication regime change
- ☐ No
- ☐ Yes, please describe:

ECT treatment reviewed by	_____ **(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:		Hair dry & clean	
• Medical record / file (with any previous ECT-EEG tracings)		Face clean & makeup removed	
• Medication chart (check any pre-medication given & signed)		Contact lenses & spectacles removed	
• Consent form: valid, completed & signed		Hearing aids removed	
• ECT-PRESCRIBE form: completed & signed by psychiatrist in-charge		Dentures removed	
Pre-ECT observation in ward:		Fingernails clean & nail polish removed	
Orientation: time, place, person	☐ Yes ☐ No	Jewellery removed	
Temperature (°C):		Patient encouraged to use the toilet	
Heart rate (bpm):			
Respiratory rate (BPM):			
Blood pressure (mmHg):			
SpO_2 (%):			

Pre-ECT treatment checklist done by:	_____ **(Signature & Name: Staff In-charge)** **Date & Stamp:**

MINISTRY OF HEALTH, MALAYSIA
DEPARTMENT OF PSYCHIATRY & MENTAL HEALTH

HOSPITAL _____ (name of hospital)

ECT TREATMENT SESSION FORM (ECT-SESSION form)

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:	
Orientation: time, place, person	☐ Yes ☐ No	_____ (Signature & Name: ECT Co-ordinator) Date & Stamp:
Temperature (°C):		
Heart rate (bpm):		
Respiratory rate (BPM):		
Blood pressure (mmHg):		
SpO_2 (%):		

TIME-OUT ITEMS

☐ **Correct patient** ☐ **Dentures out** ☐ **Bite block ready** ☐ **Correct electrode placement (stimulus & recording)** ☐ **Consent form valid, completed & signed** ☐ **ECT-PRESCRIBE form completed & signed** ☐ **Pre-ECT treatment observation done** ☐ **Stimulus dose checked** ☐ **Pulse width checked** ☐ **Correct anaesthetic drugs (type & dose)**	To proceed ☐ **YES** ☐ **NO**	_____ (Signature & Name: ECT Administering Psychiatrist / ECT Medical Officer) Date & Stamp: _____ (Signature & Name: ECT Co-ordinator) Date & Stamp: _____ (Signature & Name: Anaesthesia Provider) Date & Stamp:

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%

1st STIMULUS DOSE ☐☐☐%		2nd STIMULUS DOSE ☐☐☐%	
DURATION (s)	☐ Adequate (4-5 / 5)	DURATION (s)	☐ Adequate (4-5 / 5)
Motor Seizure:	☐ Equivocal (3 / 5)	Motor Seizure:	☐ Equivocal (3 / 5)
EEG Seizure:	☐ Inadequate (0-2 / 5)	EEG Seizure:	☐ Inadequate (0-2 / 5)
3rd STIMULUS DOSE ☐☐☐%		4th STIMULUS DOSE ☐☐☐%	
DURATION (s)	☐ Adequate (4-5 / 5)	DURATION (s)	☐ Adequate (4-5 / 5)
Motor Seizure:	☐ Equivocal (3 / 5)	Motor Seizure:	☐ Equivocal (3 / 5)
EEG Seizure:	☐ Inadequate (0-2 / 5)	EEG Seizure:	☐ Inadequate (0-2 / 5)

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:**

MINISTRY OF HEALTH, MALAYSIA
DEPARTMENT OF PSYCHIATRY & MENTAL HEALTH

HOSPITAL _____ (name of hospital)

ECT TREATMENT SESSION FORM (ECT-SESSION form)

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	☐ Alert ☐ Drowsy/ Confused/ Delirious ☐ Unconscious	☐ Alert ☐ Drowsy/ Confused/ Delirious ☐ Unconscious	☐ Alert ☐ Drowsy/ Confused/ Delirious ☐ Unconscious	☐ Alert ☐ Drowsy/ Confused/ Delirious ☐ Unconscious	☐ Alert ☐ Drowsy/ Confused/ Delirious ☐ 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	☐ Alert ☐ Drowsy/ Confused/ Delirious ☐ Unconscious	☐ Alert ☐ Drowsy/ Confused/ Delirious ☐ Unconscious	☐ Alert ☐ Drowsy/ Confused/ Delirious ☐ Unconscious	☐ Alert ☐ Drowsy/ Confused/ Delirious ☐ Unconscious	☐ Alert ☐ Drowsy/ Confused/ Delirious ☐ Unconscious	☐ Alert ☐ Drowsy/ Confused/ Delirious ☐ Unconscious
Orientation	☐ Time ☐ Place ☐ Person	☐ Time ☐ Place ☐ Person	☐ Time ☐ Place ☐ Person	☐ Time ☐ Place ☐ Person	☐ Time ☐ Place ☐ Person	☐ Time ☐ Place ☐ Person
Temperature						
Heart rate						
Respiratory rate						
Blood pressure						
SpO_2						
Side effect(s) e.g. broken tooth, muscle ache	☐ Yes i.e. _____ ☐ No	☐ Yes i.e. _____ ☐ No	☐ Yes i.e. _____ ☐ No	☐ Yes i.e. _____ ☐ No	☐ Yes i.e. _____ ☐ No	☐ Yes i.e. _____ ☐ No
Tolerated orally	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Gait	☐ Stable ☐ Unstable	☐ Stable ☐ Unstable	☐ Stable ☐ Unstable	☐ Stable ☐ Unstable	☐ Stable ☐ Unstable	☐ Stable ☐ Unstable
Stable to cease observation	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Cannula removed	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Comments (if any):

Post-ECT recovery in ward / daycare done by:

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