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: ______________

Appendix 3

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: ________________

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.**