

Consent to electroconvulsive therapy

I have been informed t that I / the patient First name: _____ Family name: _____
– _____ is suffering from a mental state which is expressed by

I have been informed that in this mental state I may be helped by a treatment or a repeated .treatment of electroconvulsive therapy

I have been told that this treatment is done using the appropriate instrument by attaching .metal electrodes to the skin of the head and transfer of an electric current for a short time

I have been told that, as any medical treatment, this treatment is not free of complications and potential risks. The treatment can have side effects such as headaches, muscle pain, feeling of "confusion", transitory problems in short term memory. The treatment is done under general anesthesia using muscle relaxant, and therefore carries the usual risks of such .anesthetics

After I have understood all of the above, and had the opportunity to ask clarifying questions, .and these questions were answered, I agree to the proposed treatment

:A. Patient

_____ First name: _____ Family name: _____ ID _____
_____ :Address: _____ Date: _____ Signature

:B. Relative

_____ Type of relationship _____
_____ First name: _____ Family name: _____ ID _____
_____ :Address: _____ Date: _____ Signature

C. The doctor receiving the consent

I, Dr. First name: _____ Family name: _____ License No. _____
_____ hereby declare that I have explained all of the above. After I have answered all of the person's questions and verified that he or she understand all the above information regarding the proposed treatment, including its benefits, risks and complications, the person .specified above signed the consent form in my presence

_____ :Date: _____ Doctor 's signature





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השירות לבריאות הנפש
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