Declaration of Informed Consent and Capacity

I met with and evaluated my patient:

Patient Name:
Date of Evaluation:____ / ____ / _____

I believe that all reasonable treatment modalities have been carefully considered, and that electroconvulsive therapy (ECT) is indicated and represents the least drastic alternative available for this patient at this time.

Based on my evaluation, I find that the patient:

- Understands the risks and benefits of ECT treatments, and
- Has the capacity to voluntarily provide informed consent for ECT treatments.

Signature, Attending Psychiatrist:

, M.D.

Date: ____ / ____ / _____

Printed Name:

NOTE:
The declaration below serves as verification that you have evaluated the patient and determined that he/she has the capacity to provide informed consent for ECT treatment.

- During the time the patient is receiving ECT, you must re-evaluate capacity **every 30 days** .
- Subsequent second-opinion capacity letters must be faxed to 415-925-7664 and received at least 48 hours prior to the scheduled treatment, or the session will be canceled.
- You remain responsible for managing your patient's psychotropic medications throughout the course of ECT.