

BAR CODE LABEL

RUSH UNIVERSITY MEDICAL CENTER
Chicago, Illinois

GENERAL INFORMED CONSENT

1. I hereby authorize _____ and/or _____ and/or _____ and/or such assistants and associates as may be selected by him/her/they to perform the following procedure(s)/treatment(s) upon the patient.

Procedure(s)/Treatment(s) **A maximum of _____ Unilateral or Bilateral Electroconvulsive Therapy Treatments**

2. I understand that this procedure(s)/treatment(s) appears indicated by the diagnostic and/or clinical observations performed. A licensed health care provider has explained to me the following:

- The nature of the proposed care, treatment, services, medications, interventions, or procedures
- Potential benefits, risks, or side effects, including potential problems related to recuperation
- The likelihood of achieving care, treatment, and service goals
- Reasonable alternatives to the proposed care, treatment, and service
- If warranted, the relevant risks, benefits, and side effects related to alternatives, including the possible results of not receiving care, treatment, and services
- When indicated, any limitations on the confidentiality of information learned from or about the patient

I understand the explanation provided and give this consent voluntarily.

3. I understand that some physicians who may be treating me or the above-noted patient are not employees or agents of Rush University Medical Center but are independent medical practitioners who are solely and exclusively responsible for the exercise of their medical judgment.
4. I acknowledge that I have received no warranties or guarantees with respect to the benefits to be realized or consequences of the aforementioned procedure(s)/treatment(s).
5. I authorize the administration to the patient of anesthetics determined to be necessary or advisable by the physician responsible for administering or for supervising the administration of anesthetics. In this regard, I have been fully advised as to the nature and purpose of the anesthesia, the possible risks and complications, and possible alternative anesthesia methods and I understand the explanation I have received.
6. I authorize the administration of blood and blood products to the patient as may be considered necessary or advisable in connection with the procedure(s)/treatment(s) described above. A licensed health care provider has explained the potential benefits, risks, or alternatives to receiving blood and blood products to the patient.
7. I consent to the photographing or televising of the procedure(s)/treatment(s) to be performed, including appropriate portions of the patient's body, for medical, scientific or educational purposes, provided his/her identity is not revealed by the pictures or by descriptive texts accompanying them.
8. For the purpose of advancing medical education, I consent to the admittance of observers to the room in which the procedure(s)/treatment(s) is performed.
9. I consent to the disposal by Medical Center authorities of any tissues or body parts which may be removed.
10. I have informed the licensed health care provider that to my knowledge I have allergies to the following substances and drugs:

(If none, leave blank) _____

(OVER)

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11. I acknowledge that I have read this document and the information sheet entitled (if no information sheet is provided, leave blank) What is Electroconvulsive Therapy (ECT)? and that I fully understand them.

Date: _____

Signature of Consenting Party

Time: _____ A.M. / P.M.

Print Name

WITNESS TO SIGNATURE OF CONSENTING PARTY:

IF CONSENTING PARTY IS OTHER THAN PATIENT:

Signature of Witness

Signature of Consenting Party

Print Name

Print Name

Relationship

INFORMED CONSENT AFFIRMATION

My signature below affirms that prior to the time of the procedure, I explained to the patient and/or his/her guardian the nature of the proposed treatment; potential benefits, risks or side effects; the likelihood of achieving treatment goals; if warranted, the relevant risks, benefits, and side effects related to alternatives; and, when indicated, any limitations on the confidentiality of information learned from or about the patient.

Date: _____

Signature of Licensed Health Care Provider

Print Name

TELEPHONE CONSENT

Verbal authorization for the procedure(s)/treatment(s) in paragraph 1 above was obtained from the consenting party named below who has stated that he/she has authority to consent on behalf of the patient following an explanation of the information in paragraph 2 above.

Date: _____

Print Name of Consenting Party

Time: _____ A.M. / P.M.

Relationship to Patient

WITNESS AND RECIPIENT OF CONSENT:

Signature of Witness

INSTRUCTIONS: This consent form should be signed by the patient if an adult (18 years and older), by a parent or court-appointed guardian if the patient is a minor or by a court-appointed guardian if the patient has been declared legally incompetent.