NORTH CAROLINA BAPTIST HOSPITAL
INFORMED CONSENT – REQUEST FOR OPERATION
(Abbreviations and Symbols ARE NOT Acceptable On This Form)

Date: ___________________ Time: ___________________
(Date Patient signs form) A.M. or P.M (circle one)

1. I have been told by my physician that I have been diagnosed as having the following condition: _______________________

My physician has recommended the following procedures(s). (Indicate whether right or left, when appropriate.)

**Electroconvulsive Therapy (ECT)**

(which will involve appropriate anesthesia and may include the use of blood products*) to be performed by a physician and his/her designated assistants. I have been advised of possible risks and consequences associated with the recommended procedure including, but not limited to: Headache, jaw pain, muscle soreness, and nausea, difficulties in attention and concentration, memory loss. The risk of death from ECT is very low, about 1 in 10,000 patients.

2. I understand that, in addition to doing nothing, there are alternatives to the recommended procedure including:

   **Medications**
   I have been advised of the possible risks and consequences of these alternatives as they compare to the recommended procedure.

3. I have been advised that sometimes during a procedure it is discovered that an additional procedure is needed immediately. Except as noted below, I authorize my physician to proceed with such additional procedures: (If no exception, write “none”).

   **None**

4. I understand the Hospital is a teaching institution, and I agree that students training to be physicians, nurses, and allied health personnel may assist in providing my care. I understand that Healthcare industry representative(s) or similar visitors may be present in the operating room based on the discretion and approval of the physician and Hospital, and I give my consent to this.

5. I acknowledge that no guarantee as to outcomes have been made concerning this procedure. I have been advised that if I desire, my physician will give me a further or more detailed explanation concerning my diagnosis, recommended and alternative procedures, or possible risks and consequences. I am satisfied with the explanation given to me, and authorize my physician and others as may be selected by my physician to perform the recommended procedure noted above.

6. I understand and give my permission that anything removed from me during the procedure (1) will be examined and reported according to Hospital policies; (2) will be disposed of in a manner deemed appropriate by the Hospital; and (3) may be used for scientific, developmental technology, research, or educational purposes.

7. I understand and give my permission that photographic or video images of the procedure outlined above may be made for purposes of medical documentation, research, or education.

Witness Date Patient’s Signature or Legal Representative

Witness (ONLY If an “X” used for signature) Date

I have personally explained the above information to the patient or the patient’s legal representative.

Physician’s Signature Date