Mental Health Services

ECT Nursing Procedure Record

(To be completed by Nursing prior to each treatment)

AFFIX LABEL HERE

Date YYYY/MM/DD	TREATMENT NUMBER	ECT machine Inspection	Patient ID Checked	NPO After 24 hours	Dentures Removed (Y/N)	Contacts/Eyeware/ Hearing Aides Removed (Y/N)	Jewellery Removed (Y/N)	Nailpolish/ Make-up, Bobby Pins Removed (Y/N)	Patient Weight kg	Patient Height cm	Patient Voided (Y/N)	Temperature	Pulse	Respirations	Blood Pressure	Oxygen Saturation	Glucometer Reading (if diabetic) Time of Reading	Pre-ECT Medications Given and Time	Physician's Order for ECT Written (Y/N)	Consent Complete-date signed	Nurses Signature