AFFIX LABEL HERE

Mental Health Services
Adult Treatment and Rehabilitation Services Program

Pre-ECT Medical Clearance Form

Baseline general physical exam and Review of Symptoms completed within one month of expected start date of ECT?

☐ Yes Date Completed: ____________________

Are there any medical conditions present that may increase risk of adverse effects of ECT?

☐ Yes ☐ No

If Yes, please specify:

☐ Space occupying cerebral lesion ☐ Increased intracranial pressure ☐ Recent myocardial infarction

☐ Aneurysm or CVA ☐ Retinal detachment ☐ Pheochromocytoma

☐ Other: ____

Are there any medical conditions that may require modifications to ECT technique?

☐ Yes ☐ No

If Yes, please specify:

☐ COPD ☐ Hypertension ☐ History of myocardial infarction ☐ History of CVA

☐ Asthma ☐ Coronary artery disease ☐ Cardiac arrhythmia's ☐ Osteoporosis

☐ Other: ____

Are there any conditions or historical factors that may require Pre-ECT Anesthesia consult?

☐ Yes ☐ No

Specify Patient Risk Factors:

☐ Ischemic Heart disease:

☐ Severe (class 3 or 4 angina) ☐ MI<6 months ago

☐ New onset of symptoms/ECG changes ☐ Unstable or progressive symptoms

☐ Recent CHF (<3 months) ☐ Morbid obesity (BMI > 45)

☐ Severe heart valve disease ☐ Progressive changing neurologic disease

☐ Decreased exercise ability ☐ Muscular disorders (ie. Duchenne/Myotonic Dystrophy etc)

☐ Severe lung disease ☐ Renal Failure or cirrhosis

☐ Severe/poorly controlled HTN/Diabetes ☐ Coagulation disorders

☐ Obstructive Sleep apnea

Specify Anesthesia Factors:

☐ Malignant Hyperthermia ☐ Unexpected post op ventilation/severe breathing problems

☐ Previous difficult intubation ☐ Anaphylaxis to anesthetic medication

AFFIX LABEL HERE

Mental Health Services
Adult Treatment and Rehabilitation Services Program

Pre-ECT Medical Clearance Form

Completion of Pre-ECT Procedure, Assessments, Lab and Diagnostic Investigations:

☐ Baseline MoCa ☐ ECG ☐CXR ☐ CBC, Na, K, Cl, Creatinine, Fasting Glucose

☐ Other: ______________________________

☐ Medication Review ☐ Allergy Review

Abnormal Results:

☐ Internal Medicine Consult ☐ Family Medicine Consult

Reason: ______________________________

☐ Anesthesia Consult

Reason: ______________________________

Physician Signature	Print Name/Designation	Date	Time