ELECTROCONVULSIVE THERAPY (ECT) FORM

Resident:_____

This form is used to document a resident's training in the use of ECT. Training in the use of ECT is determined by the criteria listed below. It is recognized that a resident's future competence in the use of ECT will be determined by his or her continued training and use of the procedure.

PATIENT'S INITIALS: _____

Dates of ECT Performed by Resident
(Staff Psychiatrist in attendance should initial at each date ECT was given)

1._____ _____
2._____ _____
3._____ _____
4._____ _____
5._____ _____
6._____ _____
7._____ _____
8._____ _____
9._____ _____

COMMENTS

Were indications noted?	Yes	No
Were contraindications noted?	Yes	No
Was pre-ECT work-up complete?	Yes	No
Was technique appropriate?	Yes	No
Were adverse effects monitored?	Yes	No
Was post-ECT follow-up appropriate?	Yes	No
Were there complications? *(If yes, explain in COMMENTS)*	Yes	No

_____ _____
Signature of Resident Date Signature of Staff Psychiatrist in Attendance Date

APPROVED FOR SUBMISSION INTO RESIDENT'S PERMANENT FILE

_____
Signature of Psychiatry Residency Director Date