ELECTROCONVULSIVE THERAPY
PRE-TREATMENT REVIEW COMMITTEE STATEMENT

(For involuntary clients, persons under guardianship/conservatorship,
voluntary clients without capacity, and voluntary clients without verification of capacity)

We, the undersigned physicians, have reviewed the treatment record of client, _____, which included the psychiatric history and
Client
examination by _____, M.D., as well as specific
Treating Physician
statements by _____, M.D., indicating the reasons for
Treating Physician
the choice of Electroconvulsive Therapy (ECT), that all reasonable treatment modalities have been carefully considered, that ECT is definitely indicated, and that ECT is the least drastic alternative available for this client at this time.

Based on personal examination of the client by _____, M.D.,
Consulting Physician
and our review of the client's treatment record, we agree with the opinion and recommendation of _____, M.D., that ECT is the treatment of choice
Treating Physician
for the welfare of this client.

_____ _____
Consulting Physician's Signature (Appointed by Facility) Date

_____ _____
Consulting Physician's Signature (Appointed by Local Mental Health Plan Director) Date