

REPORT OF ECT AND OTHER THERAPIES

In keeping with provisions mandated in the Texas Health and Safety Code, Title 7, Subtitle C, Chapter 578, the Texas Department of Mental Health and Mental Retardation is required to collect, analyze, and report data relating to the use of electroconvulsive therapy (ECT) and other non-ECT psychiatric treatments, including psychosurgery, prefrontal sonic sound treatment, and coma-producing therapies. In order to facilitate this purpose, this form must be completed for each patient who receives ECT or other reportable treatment. Patients' identities will not be revealed in any report generated from data on this form. TXMHMR summary reports are generated each quarter (January 15, April 15, July 15, October 15) and annually (October 15). The annual report is submitted to the Governor and members of the legislature, as required by law.

<p><u>Send completed form to:</u> Connie Jimenez, ECT Database Coordinator Office of Decision Support Department of State Health Services P.O.Box 149347, Mail Code 2114 Austin, TX 78714-9347</p>	<p><u>For treatment administered during:</u> September, October, November December, January, February March, April, May June, July, August</p>	<p><u>Reports are due on or before:</u> December 31 March 31 June 30 September 30</p>
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FORM PREPARED BY

Name:	Title:	Phone Number:
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INFORMATION ON FACILITY WHERE ECT WAS ADMINISTERED

Name of facility:	Date of most recent ECT:	Physician performing ECT:	Psychiatrist ordering ECT:
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PATIENT INFORMATION

<p>Consent status: (check one only)</p> <p><input type="checkbox"/> Voluntary patient consenting <input type="checkbox"/> Involuntary patient consenting <input type="checkbox"/> Guardian consenting for involuntary patient</p>		<p>Primary source of payment: (check one only)</p> <p><input type="checkbox"/> private 3rd party (insurance company, HMO, etc.) <input type="checkbox"/> public 3rd party (county, state, Medicare, Medicaid, etc.) <input type="checkbox"/> own/family funds <input type="checkbox"/> other (please specify):</p>	
<p>Gender:</p> <p><input type="checkbox"/> Female <input type="checkbox"/> Male</p>	<p>Age:</p>	<p>Race/Ethnicity (check only one):</p> <p><input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White/Caucasian</p>	

DIAGNOSTIC INFORMATION

DSM diagnosis: (DSM code preferred)	Type of stimulus equipment used:
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TREATMENTS ADMINISTERED DURING THIS REPORTING PERIOD

<p style="text-align: center;">Series Treatments Only</p> <p>◆ Bracket the number of treatments in the series. ◆ Circle the series treatments administered during this reporting period. Example: [1 2 3 4 5 ⑥ ⑦ ⑧ ⑨ ⑩] 11 12 13 14 15 16 17 18 19 20</p> <p style="text-align: center;">1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24</p> <p>◆ Series Status (check one): <input type="checkbox"/> ongoing <input type="checkbox"/> concluded <input type="checkbox"/> stopped</p>	<p>Number of Maintenance Treatments Only</p>	<p>Total Treatments This Quarter</p>
<p>If treatment series was prematurely stopped, why:</p>	<p>If more than 24 treatments in a 12-month period, or 15 treatments in an 8-week period were administered, was written concurrence of a fully-qualified psychiatrist not involved in the patient's care obtained prior to administration? <input type="checkbox"/> yes <input type="checkbox"/> no</p>	

REPORTABLE EVENTS

Within 14 days of treatment, did any of the following events occur?

fracture/specify location_____ apnea reported memory loss cardiac arrest death*

Specify how many days after treatment by circling the number: 1 2 3 4 5 6 7 8 9 10 11 12 13 14

*The Texas Health and Safety Code §578.007(b)(8) requires ECT providers to report autopsy findings if death followed within 14 days of administration of ECT. However, the Texas Code of Criminal Procedure, Chapter 49, Article 49.05, provides that proper consent be obtained from the legal next of kin before an autopsy can be performed.

PHYSICIAN ASSESSMENT OF MEMORY LOSS

Memory:

(a) Generally, what level of memory impairment, if any, was present *before* beginning this treatment series or maintenance ECT?

none mild moderate severe extreme

(b) Generally, what level of memory impairment, if any, was present 2-4 weeks (but not more than one month) *after* the last treatment?

none mild moderate severe extreme

Treatment response:

(a) Generally, what level of symptom severity or disability was present *before* beginning this treatment series or maintenance ECT?

none mild moderate severe extreme

(b) Generally, what level of symptom severity or disability was present 2-4 weeks *after* this treatment series (or after the most recent maintenance ECT)?

none mild moderate severe extreme

OTHER REPORTS REQUIRED UNDER TEXAS HEALTH AND SAFETY CODE, CHAPTER 578

If any of the following treatments were administered during the time period reported on this form, please report number of treatments administered.

Treatments _____ **Multiple-monitored ECT:** The induction of more than one adequate seizure during one episode of anesthesia.

_____ **Regressive or depatterning ECT:** The prolonged use of daily or more frequent treatments.

_____ **Insulin coma treatment:** The production of a coma for therapeutic purposes through the administration of insulin.

_____ **Prefrontal sonic sound treatment:** The direct stimulation and/or destruction of brain cells or brain tissue by ultrasound for therapeutic purposes.

_____ **Psychosurgery:** Surgical intervention to sever fibers connecting one part of the brain with another or to remove or to destroy brain tissue with the intent of modifying or altering severe disturbances of behavior, thought content, or mood.

_____ **Other:** Any other convulsive or coma-producing therapy to treat mental illness.