ECT CHECKLIST

Please complete this sheet and send with the patient for each appointment

Name of Transporter and telephone number _____

General Mood _____

Has the patient eaten or drank anything after midnight? Yes No

Percentage of meal eaten at last meal _____

Number of hours slept _____ Morning Weight _____

Vital signs: Temperature _____Pulse _____ Respirations _____B/P _____

Allergies _____

MEDICATIONS: Please complete for each visit even if the medications have not changed. Give all heart and blood pressure medications the morning of the procedure with sips of water.

Name of Medication	Dose	Frequency	Last time given (Date & Time)

Signature of Caregiver and telephone number _____