

CONVULSIVE TREATMENTS ADMINISTERED – QUARTERLY REPORT

| | | |
|--------------------|--|---|
| County | Reporting Facility or Doctor | Report Date |
| For Quarter Ending | Number of Patients Treated By Major Source of Payment | Private: _____ Public: _____ 3rd Party Payor: _____ Other: _____ |

SECTION I NUMBER OF PATIENTS RECEIVING TREATMENT

| PATIENT DISTRIBUTION PATIENT TYPE | AGE | | | | | | | | SEX | | | RACE | | | | | | | |
|---|---------|---------|---------|---------|---------|-----|---------|--------|------|--------|--------|-------|-------|----------|-------|--------------|----------|-------|--------|
| | 12 - 15 | 16 - 17 | 18 - 24 | 25 - 44 | 45 - 64 | 65+ | Unknown | Totals | Male | Female | Totals | White | Black | Hispanic | Asian | Amer. Indian | Filipino | Other | Totals |
| Voluntary Patient - With Informed Consent | | | | | | | | | | | | | | | | | | | |
| Voluntary Patient - Not capable of Informed Consent | | | | | | | | | | | | | | | | | | | |
| Involuntary Patient - With Informed Consent | | | | | | | | | | | | | | | | | | | |
| Involuntary Patient - Not Capable of Informed Consent | | | | | | | | | | | | | | | | | | | |
| TOTALS | | | | | | | | | | | | | | | | | | | |

SECTION II TOTAL TREATMENTS GIVEN

| | | | | | | | | | | | | | | | | | | |
|-----------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| Convulsive Treatments | | | | | | | | | | | | | | | | | | |
|-----------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|

SECTION III COMPLICATIONS ATTRIBUTABLE TO TREATMENT

| | | | | | | | | | | | | | | | | | | |
|-----------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| Cardiac Arrest - Nonfatal | | | | | | | | | | | | | | | | | | |
| Memory Loss - reported | | | | | | | | | | | | | | | | | | |
| Fractures | | | | | | | | | | | | | | | | | | |
| Apnea | | | | | | | | | | | | | | | | | | |
| Death - No Coroner Report | | | | | | | | | | | | | | | | | | |
| Death - With Coronor Report | | | | | | | | | | | | | | | | | | |
| TOTALS | | | | | | | | | | | | | | | | | | |

SECTION IV EXCESSIVE TREATMENTS

| | | | | | | | | | | | | | | | | | | |
|---------------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| Patients - Excessive Treatments | | | | | | | | | | | | | | | | | | |
|---------------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|

PREPARED BY: _____

SUBMIT TO: _____

TELEPHONE NUMBER (including area code): () _____

County Mental Health Director

DO NOT MODIFY THIS FORM FOR SUBMITTAL TO THE DEPARTMENT OF HEALTH CARE SERVICES