

Patient Name: _____ Facility/Facility TIN _____
 DOB & ID: _____ Contact: _____
 Primary Diagnosis: _____ Contact Phone #: _____
 Level of Care: Inpatient Outpatient Inpatient with transition to outpatient
 If outpatient, does patient have access to reliable transportation for treatment? Yes No
 Requested number of sessions: _____ Frequency and Duration of sessions: _____
 Start date of treatment: _____ MD performing treatment: _____

*****For concurrent/ongoing requests, please go directly to Page 3*****

- Briefly describe why ECT is being requested for this patient, including the severity of the patient's symptoms, and chronic maladaptive behaviors that manifest in social/occupational settings.

- Was a second opinion obtained for treatment? Yes No
- Are there any absolute/and or relative contraindications that would preclude treatment? If yes, please explain

- Has the patient received a medical clearance for the treatment? Yes No
- Do you have a signed informed consent for ECT treatment in the record? Yes No
- What rating scales will be used to determine efficacy of treatment? (i.e. Beck Depression Inventory, PHQ-9, MADRS) Pre-treatment Score: _____
- Please list all medication trials over the last 6 months, including response.

Medication name/s	Drug Class	Max Dose	Time period	Response	Side effects	Current med?

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8. If the patient is not currently hospitalized, list dates of hospitalization if applicable.
9. Has the patient been adherent with outpatient treatment and treatment recommendations over the last 6 months?
10. Does this patient have a history of Self Injurious Behavior or suicide attempts or gestures?
 Yes No If yes, please describe:
11. Does this patient have a prior history of response to ECT? Yes, if yes, please indicate below.
 No prior ECT treatment

Treatment Dates	No. of Sessions	Side Effects	Response

Complete the following for Concurrent reviews only

Date of last session completed:

Number of Sessions Completed:

Requested Start Date of Next Session:

Estimated Series End Date:

Frequency and Duration of sessions:

Primary Diagnosis if changed:

Level of Care: Inpatient Outpatient Inpatient with transition to outpatient

Rating scales used to determine efficacy of treatment? (i.e. Beck Depression Inventory, PHQ-9, MADRS):

Most recent interim Score (as applicable):

Electrode Placement: Unilateral Bilateral Seizure Duration:

Side Effects:

Medication Changes:

Long term plan: