Request to Authorize ECT

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

1. 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.

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

4. Has the patient received a medical clearance for the treatment? ☐ Yes ☐ No
5. Do you have a signed informed consent for ECT treatment in the record? ☐ Yes ☐ No
6. What rating scales will be used to determine efficacy of treatment? (i.e. Beck Depression Inventory, PHQ-9, MADRS) Pre-treatment Score:
7. 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?

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

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: