

## Electroconvulsive Therapy Initiation Request

Name of Person Completing Form: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

**CBA must have the following information to process the request:**

Patient Name: _____	Diagnosis: _____
Date-of-Birth: _____	
ID Card #: _____	Axis I _____
Requesting MD: _____	Axis II _____
MD NPI #: _____	Axis III _____
Facility: _____	Axis III _____
Facility NPI #: _____	Axis IV _____
MD Performing ECT (if different): _____	
Address Where Services are Rendered: _____	

Treatment History (include outpatient &amp; inpatient with dates, locations and lengths of stay):

 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

 Has a current medical assessment been completed? Yes  No 

 Has a current psychiatric assessment with a cognitive component been completed? Yes  No 
**Medication History (list all past medications and current medications):**

Past Medications	Dose	Duration of Rx	Response	Current Medications

List any prior ECT series and outcomes the patient has had (with dates and locations):

 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Why is the patient being referred for ECT at this time?

 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

How many treatments/what frequency are you requesting? \_\_\_\_\_

What is the projected ECT start date? \_\_\_\_\_

**Authorization is not valid until authorization # is received from CBA.**

Office use only: # of Visits Approved: _____	Date Range: _____
Auth #: _____	Reviewer: _____ Ext: _____

**Please make additional copies of this form for your office use. Thank you.**