

ELECTROCONVULSIVE THERAPY (ECT) AUTHORIZATION FORM

*ALL FEILDS MUST BE COMPLETED FOR THIS REQUEST TO BE REVIEWED.
 Please type or print neatly.

INPATIENT OUTPATIENT

DEMOGRAPHICS

Patient Name: _____

Health Plan: _____

DOB: _____

Patient ID # _____

Last Auth # _____

PREVIOUS BH/SA TREATMENT

None or OP MH SA and/or IP MH SA
 List names and dates, include hospitalizations: _____

Substance Use Disorder: None By History &/or Current/Active
 Substance(s) used, amount, frequency and last used: _____

CURRENT ICD DIAGNOSIS

Primary _____
 Secondary _____
 Tertiary _____
 Additional _____
 Additional _____

PRIMARY MEDICAL PHYSICIAN (PMP) COMMUNICATION

Has information been shared with the PMP regarding:
 The initial evaluation & treatment plan? Yes No
 This updated evaluation & treatment plan? Yes No
 PMP Name/Date last notified: _____
 If No, explain: _____

PROVIDER INFORMATION

Please indicate to whom the authorization should be made:
 Individual Provider Yes No Group/Facility Yes No
 Provider Name (print) _____
 Professional Credential: MD PhD Other _____
 Physical Address _____
(street address, city, state, zip code)

Phone# _____ Fax# _____

Hospital where ECT will performed: _____

Medicaid/TPI/NPI# _____

Medicaid Tax ID# _____

CURRENT RISK/LETHALITY

	1 NONE	2 LOW *	3 MOD*	4 HIGH*	5 EXTREME*
Suicidal					
Homicidal					
Assault/ Violent Behavior					
Psychotic Symptoms:					

*3, 4, or 5 please describe what safety precautions are in place

PCP COMMUNICATION

Has information been share with the PMP regardinf Behavioral Health Provider Contanct information. Date of initial Visit, presenting Problem, Diagnosis and Medications Perscribed (if applicable)?

PMP communication completed on _____ via: Phone Fax Mail

Member Refused By: _____
(signature/Title)

Coordination of care with other behavioral health providers?

Has informed consent been obtained from patient/gaurdian? _____

Date of most recent psychiatric evaluation: _____

Date of most recent physicalexawminationandindicationifanesthesiology consult was compleated: _____

REQUESTED AUTHORIZATION FOR ECT

Please indicate type(s) of services provided **BY YOU** and the frequency):

Total sessions requested: _____

Type: _____ Bilateral _____ Unilateral

Frequency: _____

Date first ECT: _____ Date first ECT: _____

Est. # of ECTs to complete treatment: _____

Requested start date for authorization? _____

Last ECT info: Length: _____

Lenght of convulsion: _____

CURRENT PSYCHOTROPIC MEDICATIONS

Name	Dosage	Frequency

DISCHARGE GOALS

Please indicate current accute syptoms member is Experiencing:

Please indicade any present or past histry of medical problems including allergies, seizure history and if member is pregnant:

REASON FOR ECT NEED

Please objectively define the reasons ECT is warranted including failed lower levels of care (including and medicaton trials):

Please indicate what education about ECT has been provided to the family and which responsible party will transport patient to ECT appointments:

ECT outcome

Please indicate progress member has made to date with ECT treatment:

ECT discontinuation

Please objectively define when ECT will be discontinued-- what changes has ocurred:

Please indicate the plans for treatment and medications once ECT is completed:

Provider Name

Provider Signature

Date