SUBMIT TO
Utilization Management Department
PHONE 1.800.224.1991 | FAX 1.866.694.3649

ELECTROCONVULSIVE THERAPY (ECT)

Please print clearly – incomplete or illegible forms will delay processing.

DEMOGRAPHICS

Patient Name ______

Health Plan ______

DOB ______

SSN ______

Patient ID ______

Last Auth # ______

PREVIOUS BH/SUD TREATMENT

☐ None or ☐ OP ☐ MH ☐ SUD and/or ☐ IP ☐ MH ☐ SUD

List names and dates, include hospitalizations ______

______

Substance Use Disorder

☐ None ☐ By History and/or ☐ Current/Active

Substance(s) used, amount, frequency and last used ______

______

CURRENT ICD DIAGNOSIS

Primary ______

R/O ______ R/O ______

Secondary ______

Teritary ______

Additional ______

Additional ______

Danger to Self or Others (If yes, please explain)? ☐ Yes ☐ No

MSE Within Normal Limits (If no, please explain)? ☐ Yes ☐ No

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

______

PROVIDER INFORMATION

Provider Name (print) ______

Hospital where ECT will be performed ______

Professional Credential: ☐ MD ☐ PhD ☐ Other ______

Physical Address ______

Phone ______ Fax ______

Medicaid/TPI/NPI # ______

Medicaid Tax ID # ______

REQUESTED AUTHORIZATION FOR ECT

Please indicate type(s) of service provided by YOU and the frequency.

Total sessions requested ______

Type ______ Bilateral ______ Unilateral ______

Frequency ______

Date first ECT ______ Date last ECT ______

Est. # of ECTs to complete treatment ______

Requested start date for authorization ______

LAST ECT INFO

Length ______ Length of convulsion ______

PCP COMMUNICATION

Has information been shared with the PCP regarding Behavioral Health Provider Contact Information, Date of Initial Visit, Presenting Problem, Diagnosis, and Medications Prescribed (if applicable)?

PCP communication completed on via:

☐ Phone ☐ Fax ☐ Mail ☐ Member Refused

By ______

Coordination of care with other behavioral health providers? ______

Has informed consent been obtained from patient/guardian? ______

Date of most recent psychiatric evaluation ______

Date of most recent physical examination and indication of an anesthesiology consult was completed ______

CURRENT PSYCHOTROPIC MEDICATIONS

Name	Dosage	Frequency

PSYCHIATRIC/MEDICAL HISTORY

Please indicate current acute symptoms member is experiencing ____

____

Please indicate any present or past history of medical problems including allergies, seizure history and member is pregnant ______________

____

REASON FOR ECT NEED

Please objectively define the reasons ECT is warranted including failed lower levels of care (including any medication 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 ECTs will be discontinued – what changes will have occured ______________________________

____

Please indicate the plans for treatment and medication once ECT is completed ______________________________

____

Provider Name (please print)	Provider Signature	Date

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