Show Me Healthy Kids
MANAGED BY HOME STATE HEALTH ®

SUBMIT TO
Utilization Management Department
PHONE 1.877.236.1020 | FAX 1.833.966.4342

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 ☐ SA and/or IP MH SA

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 _____

Physician Medicaid/TPI/NPI # _____

Hospital 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 _____

Name	Dosage	Frequency

CURRENT PSYCHOTROPIC MEDICATIONS
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