

ELECTROCONVULSIVE THERAPY (ECT) AUTHORIZATION REQUEST FORM

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

DOB Hospital where ECT will be performed SN Protessional Credential: IMD PhD Other Patient ID Phone Physical Address Phone Phone <th>DEMOGRAPHICS</th> <th>PROVIDER INFORMATION</th>	DEMOGRAPHICS	PROVIDER INFORMATION	
Dub Professional Credential: MD PhD SSN Physical Address Patient ID Physical Address Last Auth # PREVIOUS BH/SUD TREATMENT None or OP DMH DUD None or OP DMH DUD Requested Last and dates, include hospitalizations Substance Abuse None or By History and/or Current/Active Substance Abuse None By History and/or Current/Active Substance () used, amount, frequency and last used Primary R/O Secondary R/O Last Math II None Substance () used, amount, frequency and last used Primary R/O R/O Last ECT INFO Langth Length Length Length Length Length Length Length Length Longonsis, and Medication Prescribed (if applicable)? PCP communication completed on vic: Phone Provider Contact Information, Date of Initial Visit, Presenting Problem, Correct Information, Date of Initial Visit, Presenting Problem, Correct Information of Core with other behavioral health providers? Homicidal I HONE 2 LAST ECT INFO Last Muth II HEAH Subicidal I HONE 2 LAST ECT INFO Last Muth II HEAH Subicidal I HONE 2 LAST ECT INFO Last Information b	Patient Name	Provider Name (print)	
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	Behavior <u> </u>	Date of most recent psychiatric evaluation	
Symptoms anesthesiology consult was completed		Date of most recent physical examination and indication of an	
*3, 4, or 5 please describe what safety precautions are in place		anesthesiology consult was completed	

CURRENT PSYCHOTROPIC MEDICATIONS		
Dosage	Frequency	
	Dosage	

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 if 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 _

STANDARD REVIEW:

Standard 14-day time frame will be applied.

EXPEDITED REVIEW: By signing below, I certify that applying the standard 14-day time frame could seriously jeopardize the member's health, life or ability to regain maximum function.

Clinician Signature

Date

Clinician Signature

Date

SUBMIT TO

Utilization Management Department Phone: 1.855.694.4663 Fax: 1.877.725.7751

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