

SUBMIT TO
Utilization Management Department
 Phone: 1.866.912.6285 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 _____
 Tertiary _____
 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Homicidal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assault/ Violent Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychotic Symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*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 occurred _____

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

Provider Name (please print)

Provider Signature

Date

SUBMIT TO
Utilization Management Department
Phone: 1.866.912.6285 Fax: 1.866.694.3649