Electroconvulsive Therapy Service

Referral Form

This form is to be completed by a psychiatric provider.
Once completed, please submit the following documents via fax to (907) 212-5907 or email to PAMC.ECT@providence.org:

- Referral form;
- Insurance information [face sheet and/or copy of insurance card(s)]
- Most recent progress note; and
- Detailed clinical summary including diagnosis(-es), medical problems, current medications, past treatments, and indication for ECT.

The patient, or their legal decision maker if applicable, must provide consent and authorization for referral.

Provider Information

Referring Provider: ______________________________

Office/Clinic: ______________________________

Address: ______________________________

Phone: ______________ Fax: ______________

Email: ______________________________

Our team will be in regular contact with you regarding the status of this referral and while the patient is undergoing treatment, if applicable. How would you like to be contacted for these updates? Phone Fax Email

Throughout the course of ECT treatment, an ongoing relationship with a primary psychiatric provider is required. Psychiatrists performing ECT are acting in a procedural capacity and do not provide ongoing psychiatric care or medication management.

Patient Information

Please include insurance information via of Face Sheet and/or copy of insurance card(s)

Name: ______________ Date of Birth: ______________

Address: ______________________________

Phone#: ______________ Email: ______________

Primary Care Provider: ______________________________

Has the patient received ECT previously? Yes No

Where? ______________________________

When? ______________ # of treatments: ______________