Providence Medical Group – Behavioral Health

ECT Referral form - ***To be completed by the outpatient psychiatrist or NP and faxed to 907-212-5907, attach a detailed summary letter of patient's condition, medications, and any previous treatments. Include any documentation discussing ECT.***

Has this person had ECT before? When? _____ Where? _____

Currently does the patient require: (circle one) Index series/ Maintenance/ continuation / Not sure

Patient Name: _____ DOB: _____

Address: _____

Contact phone: _____ Email: _____

Referring psych provider (an ongoing relationship with a psychiatrist or psych NP for ongoing med management is required):_____

Office/Address_____

Phone: _____ Fax: _____

Medical provider/phone: _____ Date of last physical exam: _____

Current Medical issues_____

Other current medications and OTC meds or supplements:_____

_____

Current psychiatric diagnoses: _____

Current psychiatric medications and dosages:

_____

_____

Past medications trialed: _____

Our team will be contacting you on the status of this referral and then monthly when the patient is being treated, how would you like to be contacted for these updates?: _____

Provider signature Date

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*I am interested in ECT, and I consent for Providence staff to contact my insurance company about authorization*_____

Patient signature *Date*

*Insurance company*_____ *Phone:* _____

Subscriber number: _____ *Group number:* _____

Name and DOB of subscriber: _____*CT referral form v4 July 2018*