Sheppard Pratt
HEALTH SYSTEM

ADDRESSOGRAPH

OUTPATIENT ECT REFERRAL AND ORDER

TO BE COMPLETED BY REFERRING PHYSICIAN

Patient Name _____ Date of Birth _____

Insurance Company _____ Policy Number _____

DSM 5 Code/ICD-10 _____

_____

_____

ECT Rationale / Past Medication Trial _____

_____

Current Medications & Dosages _____

_____

Symptoms _____

Duration of Current Symptoms _____

Suicidal Ideation _____

Psychiatric History

Suicidal History _____

Chemical Dependency History _____

Inpatient / Outpatient Psychiatric Treatment _____

_____

ECT ORDER

Proposed Treatment (Bilateral or Unilateral) _____

Frequency of Treatments / Number of Treatments (i.e. 3x / week for 12 treatments) _____

_____

Referring Psychiatrist Signature _____ Date _____

Referring Psychiatrist Printed Name _____

Phone _____ Fax _____

Based on a review of the referral information, I concur that ECT treatment is appropriate and hereby order ECT in the manner described above.

ECT Psychiatrist Signature _____ Date _____

ECT Psychiatrist Printed Name _____

Fax completed form to ECT / Medical Department at 410-938-3448.
If you have any questions call 410-938-3485

Name:_____ Date: _____ Time:_____

0101211 (R 1/9/2017) (INDD)