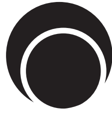 Sheppard Pratt

ADDRESSOGRAPH

OUTPATIENT ECT REFERRAL AND ORDER

TO BE COMPLETED BY REFERRING PHYSICIAN

Patient Name ______________________________ Date of Birth ______________

Patient Phone # ______________Patient Email ______________________________

Gender at Birth M / F Pronoun Preference ____________ Race (optional) ____________ Veteran Yes No

Insurance Company ______________________________ Policy Number ______________

ICD-10 Diagnosis Code ______________________________

Other Psychiatric Diagnoses______________________________

ECT Rationale / Past Medication Trials

____

Current Target Symptoms/Duration of Current Episode

____

Current Medications & Dosages

____

Current Suicidal Ideation ______________ Past Suicidal History ______________

Active or Past Substance Use Treatment ______________________________

Inpatient Psychiatric Treatment ______________________________

Last Outpatient Psychiatrist Visit ______________________________ Current Therapy Yes No

Preferred Treatment Location (optional): Towson Campus Baltimore Washington Campus

Referring Psychiatrist Signature ______________________________ Date ______________

Referring Psychiatrist Printed Name ______________________ Email ______________

Phone Number ______________________ Fax ______________________

____

FOR OFFICE USE ONLY

ECT ORDER

Number of treatments ordered: ______________Frequency of treatments: ______________

Type: ❏ Bilateral ❏ Right Unilateral ❏ Other ______________

❏ Brief ❏ Near Ultra brief ❏ Ultra brief

Based on a review of clinical information and patient evaluation, 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/ ECT@sheppardpratt.org
If you have any questions call 410-938-3485

In addition to this Referral form, please send the following documents to complete the referral packet:
❏ Current patient Insurance card (front and back) ❏ Most recent progress note with documentation that ECT has been discussed and patient is in agreement with treatment ❏ Past Medication Trials- Please provide list of previous trials including dose ranges trialed.

0101211 (R 8/9/2022) (INDD)