Sheppard Pratt

ADDRESSOGRAPH

OUTPATIENT ECT RENEWAL ORDER

TO BE COMPLETED BY REFERRING PHYSICIAN

Patient Name _____ Date of Birth _____

Patient Phone # _____Patient Email _____

Current Medication Regimen_____

Current/Ongoing Symptoms _____

Last Outpatient Psychiatrist Visit_____

Changes in Care / Other Updates

_____

Agreement for Continuing ECT Treatment ◯ 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:

Number of additional treatments ordered _____Frequency of treatments: _____

_____

Type: ☐ Bilateral ☐ Right Unilateral ☐ Other _____

☐ Brief ☐ Near Ultrabrief ☐ Ultrabrief

Based on review of clinical information and patient evaluation, I recommend the continuing ECT treatment is appropriate and hereby order ECT in the manner described above.

ECT Psychiatrist Signature_____Date _____

ECT Psychiatrist Printed Name _____

Fax or email completed form to ECT department at 410-938-3448/ ECT@sheppardpratt.org.
If you have any questions, please call 410-938-3485.

0101125 (R 8/4/2022) (INDD)