Date Received:_____

Electroconvulsive Therapy (ECT) Pre-Clearance History:

****PLEASE FILL OUT THIS FORM TO THE BEST OF YOUR ABILITY AND IN ITS ENTIRETY****

If certain information is not known (i.e., **doses of past medications**) sometimes this information can be found by calling your pharmacy or your doctor. By completing this ahead of time, it allows us more time to discuss your options and provide the best next steps in treatment. If you have questions about any of the information requested, please mark that area and proceed to the next section. We will discuss it during your visit. Additionally, you can reach us at (410) 938-3485.

We look forward to working with you and assisting you in your mental health.

- The ECT team

Full Name: _____

DOB/Age: _____

Home Address: _____

Email Address: _____

Primary Phone Number: _____ **Secondary Phone Number:** _____

INSURANCE Company: _____ **Policy Number:** _____

INSURANCE Subscriber (If you are not the primary on your insurance):

Name of Subscriber and Address: _____

Subscriber's Date of Birth: _____

Outpatient/ Referring Psychiatrist/mid-level provider (name/address/phone number):

_____

Primary Care Physician (name/address/phone number): _____

Last physical exam/wellness workup with PCP: _____

In your words, what is the reason you have been referred for ECT intervention?

_____

Do you have someone else who assists you or makes medical decisions for you? If so, please provide their name, title, email address, and phone number:

_____

Who will be able to escort (drive) you to and from ECT treatments and monitor you after treatments?

_____

Name: _____

CURRENT PSYCHIATRIC ILLNESS *(Use separate sheet if needed for additional history)*

- What current psychiatric concerns are you hoping to find improvement in by undergoing ECT interventions?

- How long have they been present? _____
- Any active thoughts of self-harm or suicide? If yes, please explain further.
  _____
- Any thoughts of wanting to harm others? If yes, please explain further.
  _____
- Any guns in the home? _____
- Current treatment
  - Current PSYCHIATRIC medications including dose, frequency, length of time at current dose

  - Other ongoing treatments/therapies: _____

PAST PSYCHIATRIC HISTORY *(Use separate sheet if needed for additional history)*

- **Past Inpatient treatment (**Date/Location/Reason)
  - _____
  - _____
- **Past Partial Hospital Program/Intensive Outpatient treatment (**Date/Location/Reason)
  - _____
  - _____
- **Past Residential treatment (**Date/Location/Reason)
  - _____
  - _____
- Age of first mental health contact/reason: _____

Current Psychiatric Treatment Team:

  - Medication management provider: _____
  - Therapist: _____
  - Any other members of medical support team (i.e., case manager/social worker)?
    _____

- **What diagnoses have been discussed with you regarding your mental health?**
  - Include all diagnoses/age received/any symptoms you remember with each diagnosis:

Name: _____

Past psychiatric medication trials/other interventions

- Please provide a full list of all psychiatric medication trials in the past. If uncertain, write down what you can remember and consider calling your pharmacy for a list of trials.
  ** Include name of medication, dose, length of treatment, possible side effects, reason discontinued. Use separate sheet if needed.
  - _____
  - _____
  - _____
  - _____
- **Other treatment interventions** in the past (i.e., ECT, Transmagnetic Stimulation, Deep Brain Stimulator, Vagal Nerve Stimulator, Ketamine infusion)
  - **ECT:** _____
  - **TMS:** _____
  - **DBS:** _____
  - **VNS:** _____
  - **Ketamine:** _____

SUBSTANCE USE: All Current and Past Usage. ***(Use separate sheet if needed for additional history)***

- _____
- _____
- _____
- _____

PAST MEDICAL HISTORY ***(please include date of all occurrences)***

- History of head trauma (i.e., Traumatic Brain Injury, concussion): _____
- History of aneurysms, brain surgery, metal implants including clips/plates, coils:
  _____
- History of strokes/Transient Ischemic Attacks: _____
- History of asthma/respiratory pathology: _____
- History of cardiac events/surgeries: _____
- Other medical history? (**See attached Review of Systems)**
- History of surgery/anesthesia? _____
  - Any difficulties with anesthesia? If yes, please explain:
    _____

CURRENT MEDICAL HISTORY

- Current medical diagnoses that you are currently under the care of a physician for:

- Current NON-PSYCHIATRIC medications including doses/side effects for other medical complaints:
  - _____
  - _____
  - _____

Name: _____

- Any current symptoms of illness? If yes, please explain.

  _____
- History of COVID-19 vaccination? Please give brand/dates if known: _____
- Any contact in the last 14 days with an individual who has tested positive for COVID-19? ○YES ○NO
- Any loose teeth/dental concerns? _____
- Any **ALLERGIES** to medications? _____
- Current **HEIGHT**: _____
- Current **WEIGHT**: _____

FAMILY HISTORY

- Any Family history of the following:
  - Seizures: _____
  - Complications from anesthesia: _____
  - Cardiac or respiratory disease before the age of 50: _____
  - Mental health diagnoses (immediate family):
    - Biological mother: _____
    - Biological father: _____
    - Biological siblings: _____
    - Biological children: _____
    - Other family of concern: _____

What are your current concerns, if any, about initiating ECT interventions?

Anything else that you feel the team should know about you or your history/care at this time?

Thank you again for providing this much needed information. Please remember to send back to the ECT department, either through the following options:

- Email: **ECT@sheppardpratt.org**
- Fax: (410) 938-3448
- Postal carrier: ECT at Sheppard Pratt, 6501 N. Charles Street, Towson, MD 21204

Once received we will be in touch with both you and your outpatient provider to review the case.

Sheppard Pratt