Sheppard Pratt

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 (include non-psychiatric medications and any vitamins/supplements)_____

_____

_____

Symptoms _____

Duration of Current Symptoms _____

Suicidal Ideation _____

Psychiatric History

Suicidal History _____

Chemical Dependency History _____

Inpatient / Outpatient Psychiatric Treatment _____

Referring Psychiatrist Signature _____ Date _____

Referring Psychiatrist Printed Name _____

Phone _____ Fax _____

__ _____

FOR OFFICE USE ONLY

ECT ORDER

Number of treatments ordered _____

Frequency of treatments: _____

Type: ❑ Bilateral ❑ Brief

❑ Right Unilateral ❑ Ultrabrief

Based on a review of the clinical 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 1/19/2021) (INDD)