

Electroconvulsive Therapy Referral by the Community/Attending Psychiatrist



Date: _____

Referring Physician

MD: _____

Phone: _____ Fax: _____

Patient Information

Name: _____ Date of Birth: _____

Phone: _____

Insurance Type: Medicare Medi-Cal Private _____ Other _____
Secondary _____

Insurance Member ID: _____

Does the patient have someone who can provide transportation to and from MarinHealth Medical Center 3 times per week? Yes No

Identifying Data:

History of Present Illness:

Substance Use History including current history for the last 6 months:

Behavioral Health

250 Bon Air Road | Greenbrae, CA 94904 | P: 415-925-7587 | F 415-925-7664
MyMarinHealth.org

Medications

| Past Medication Trials | Max Dose |
|------------------------|----------|
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| Current Medications | Dose |
|---------------------|------|
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| | |

Diagnosis

Axis 1 _____

Axis 2 _____

Axis 3 _____

Axis 4 _____

Axis 5 Current GAF _____

Highest GAF is past 12 months _____

NOTE: The Declaration below will serve as the verification that you have evaluated the patient and have determined that he/she has the capacity to give informed consent for ECT treatment. During the time period your patient is receiving ECT you will need to see your patient every 30 days for a capacity evaluation. Subsequent second opinion capacity letters can be **faxed to 415-925-7664** and must be received by 3 p.m. the day before treatment is scheduled or the treatment will have to be canceled. You will continue to be responsible for managing your patient's psychotropic medications during the period your patient is receiving ECT.

INITIAL DECLARATION OF INFORMED CONSENT AND CAPACITY

I met with and evaluated my patient _____ on _____

I believe that all reasonable treatment modalities have been carefully considered, and electroconvulsive therapy treatment is indicated and is the least drastic alternative available for this patient at this time.

Based on my evaluation the patient understands the risks and benefits of ECT treatments and has the capacity to voluntarily give informed consent for ECT treatments.

_____, MD
Signature, Community/Attending Psychiatrist

Date

_____, MD
Print Name

AUTHORIZATION TO RELEASE/EXCHANGE

CONFIDENTIAL INFORMATION

I _____ authorize _____ to:
(Patient's name) (Doctor's name)

- release to:
- obtain from:
- exchange with:

MarinHealth Medical Center
250 Bon Air Rd
Greenbrae, CA 94904

the following information pertaining to myself:

- treatment summary
- history/intake
- diagnosis
- psychological test results
- psychiatric evaluation/medication history
- dates of treatment attendance
- other (specify) _____

for the purpose of:

- evaluation/assessment and/or coordinating treatment efforts
- other (specify)

This consent will automatically expire one (1) year after the date of my signature as it appears below,
or on _____ (earlier date).

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time
(except to the extent that the information has already been released).

Signature of Client Date Date of Birth: _____

Signature of Witness Date Date of Birth: _____