marinhealth

ECT Referral Form

Date of Referral: ____/ ____ / _____

Referring Psychiatrist:

Contact Information: Phone: Fax:

Email:

Patient Information

Name:

DOB: ____ / ____ / _____

Address:

Phone #: Email:

Insurance Information

Insurance Provider:

Medical:

Policy/ID #:

Authorization # (If applicable):

Medicare ☐ Kaiser ☐

Secondary

Clinical Information

Primary Psychiatric Diagnosis:

- ☐ Major Depressive Disorder
- ☐ Bipolar Disorder (Depressed / Manic / Mixed)
- ☐ Schizophrenia / Schizoaffective Disorder
- ☐ Catatonia
- ☐ Other:

Duration of Current Episode:

Pscyhiatric Evaluation Summary

(Attach or summarize pertinent history, symptom severity, functional impairment, hospitalizations, suicidality, previous ECT response if applicable.)

Medication Trials / Treatment History

(Include dose, duration, response, and tolerability)

Medication / Therapy	Adequate Trial Response		Adverse Effects / Notes
	☐ Y ☐ N	☐ Full ☐ Partial ☐ None	
	☐ Y ☐ N	☐ Full ☐ Partial ☐ None	
	☐ Y ☐ N	☐ Full ☐ Partial ☐ None	
	☐ Y ☐ N	☐ Full ☐ Partial ☐ None	
	☐ Y ☐ N	☐ Full ☐ Partial ☐ None	
	☐ Y ☐ N	☐ Full ☐ Partial ☐ None	
	☐ Y ☐ N	☐ Full ☐ Partial ☐ None	
	☐ Y ☐ N	☐ Full ☐ Partial ☐ None	

Current Medications

(List all active medications, dose, frequency, and indication)

ECT-Specific Considerations

Indication for ECT

☐ Severe depression
☐ Treatment resistance
☐ Acute suicidality
☐ Severe psychosis
☐ Catatonia
☐ Other

ECT Referral Form - Continued

Urgency of Referral

☐ Routine ☐ Urgent ☐ Emerge

Medical Comorbidities:
Relevant Labs/Imaging:
Substance Use History: (including current and for the last six months)

Consent & Capacity

Does the patient have capacity to consent to ECT?

Yes
No (If no, has substitute decision-maker been identified who consents?

Yes
No

Does patient assent to treatment?

Transportation

Does the patient have someone who can transport them to MarinHealththree times a week?

☐ Yes No

Referring Psychiatrist's Notes

Attachments Required

Psychiatric evaluation/summary
Medication trials/treatment history
Medical clearance (if available)
☐ Recent labs (CBC, CMP, EKG)

Referring Psychiatrist Signature:

Date: ____ / ____ / _____