# ECT Preauthorization Request

| DATE | INSURED'S EMPLOYER | | |
|---|---|---|---|
| PATIENT LAST NAME | FIRST NAME | DATE OF BIRTH | AGE |

## PROVIDER INFORMATION:

| PSYCHIATRIST | PHONE | FAX | FACILITY |
|---|---|---|---|
| PRIMARY CONTACT | PHONE | FAX | REFERRING PHYSICIAN |

## DSM-5 DIAGNOSIS:

1. _____ 3. _____
2. _____ 4. _____

## PRIOR ECT?

Yes ☐ No ☐

## CURRENT PSYCHOTROPIC MEDICATIONS? Yes ☐ No ☐

**If Yes,** list all including dose and start date:

1. _____ 3. _____
2. _____ 4. _____

## TREATMENT RESISTANT DEPRESSION? Yes ☐ No ☐

**If Yes,** check all medication trials that apply:

1. Antidepressant ☐
2. Antidepressant, Different Class ☐
3. Antidepressant with Augmentation ☐
4. Tricyclic ☐
5. MAOI ☐
6. Other: _____ ☐

## ECT TREATMENT SETTING: Inpatient ☐ Outpatient ☐

**If Inpatient,** indicate the primary clinical reason below. Indicated reason must be supported by medical record.

1. Imminent Dangerousness ☐
2. Psychiatric Symptom Severity ☐
3. Medical Risk/Complications ☐
4. Functional Impairment ☐

## CURRENT ECT AUTHORIZATION REQUEST:

Initial ECT ☐ Continued ECT ☐ Maintenance ECT ☐

| ECT START DATE | NUMBER OF TREATMENTS REQUESTED WITH THIS AUTHORIZATION | REQUESTED FREQUENCY |
|---|---|---|
| NUMBER OF TREATMENTS RENDERED TO DATE | ANTICIPATED TOTAL NUMBER OF TREATMENTS | |

**If Continued ECT,** provide a brief summary of the patient's response to ECT to date:

_____

_____

_____ _____

**Physician Signature** **Date**