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 ☐

Date Completed: ________________

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. Other: ________________________ ☐

ECT TREATMENT SETTING: Inpatient ☐ Outpatient ☐

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

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:

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Physician Signature **Date**