

Department of Psychiatry
Electroconvulsive Therapy (ECT) Referral Form

Phone: 508-334-1055 Fax: 774-441-6072

Instructions: Indicate below all information about your patient. Please complete and fax clinical notes, to include psychiatric evaluation/Psych HPI, medical HPI assessment, 2 – 3 recent progress notes along with any recent labs and all clinical scales (including PHQ9, etc).

REFERRING PHYSICIAN:

Name: _____ Agency: _____
Phone: _____ Fax: _____

PATIENT INFORMATION:

Name: _____ Date of Birth: _____
Address: _____
Cell Phone: _____ Home phone: _____
Insurance and Identification #: _____

PSYCHIATRIC DIAGNOSIS: Please include ALL psychiatric diagnosis(s) based on your evaluation and information from the referring provider. Include which validation rating scales were used to support diagnosis of major depression (at least one is required and must be faxed). _____

MEDICAL CONDITION(S): _____

MEDICATION TREATMENT HISTORY (current and past): Please include dosage, efficacy, side effects, reason for discontinuation. Please also include augmenting agents.

Medication	Dose	Start Date	End Date	Reason for Discontinuing

TREATMENT HISTORY:

Please list type of Therapy: _____ Provider Giving Treatment: _____ Frequency: _____

History of seizures? Yes or No Current status: _____

History of substance use? Yes or No Current status: _____

Any ferromagnetic metals in and or around the head?

Previous TMS treatment? Yes or No When and where was the last treatment? _____

Previous ECT treatment? Yes or No When and where was the last treatment? _____