



FROM



**SUBMIT TO:**  
**Utilization Management Department**  
 Phone 1-844-518-9505 Fax: 1-844-824-7705

## ELECTROCONVULSIVE THERAPY (ECT) Authorization Request Form

\*All Fields Must Be Completed For This Request To Be Reviewed. Please type or print neatly.

Please indicate which level of care the member is currently engaged:  INPATIENT  OUTPATIENT

### DEMOGRAPHICS

Patient Name \_\_\_\_\_  
 Patient Last Name \_\_\_\_\_  
 DOB \_\_\_\_\_  
 SSN \_\_\_\_\_  
 Patient ID \_\_\_\_\_  
 Last Auth # \_\_\_\_\_

### PREVIOUS BH/SA TREATMENT

None or  OP  MH  SA and/or  IP  MH  SA  
 List names and dates, include hospitalizations \_\_\_\_\_  
 \_\_\_\_\_  
 Substance Use  None  By History and/or  Current/Active  
 Substance(s) used, amount, frequency and last used \_\_\_\_\_  
**Current ICD Diagnosis**  
 Primary (Required) \_\_\_\_\_  
 Secondary \_\_\_\_\_  
 Tertiary \_\_\_\_\_  
 Additional \_\_\_\_\_  
 Additional \_\_\_\_\_

### CURRENT RISK/LETHALITY

	1 NONE	2 LOW	3 MOD*	4 HIGH*	5 EXTREME*
Homicidal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assault/ Violent Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicidal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depressive Symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychotic Symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Manic Symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

\*3, 4, or 5 please describe what safety precautions are in place  
 \_\_\_\_\_  
 \_\_\_\_\_

### PROVIDER INFORMATION

Provider Name (print) \_\_\_\_\_  
 Hospital where ECT will be performed \_\_\_\_\_  
 Professional Credential:  MD  PhD  Other \_\_\_\_\_  
 Physical Address \_\_\_\_\_  
 Phone \_\_\_\_\_ Fax \_\_\_\_\_  
 TPI/NPI # \_\_\_\_\_ Tax ID # \_\_\_\_\_

### REQUESTED AUTHORIZATION FOR ECT

Please indicate type(s) of service provided by YOU and the frequency.  
 Total sessions requested \_\_\_\_\_  
**Type** Bilateral \_\_\_\_\_ Unilateral \_\_\_\_\_  
 Frequency \_\_\_\_\_  
 Date first ECT \_\_\_\_\_ Date last ECT \_\_\_\_\_  
 Est. # of ECTs to complete treatment \_\_\_\_\_  
 Requested start date for authorization \_\_\_\_\_

### LAST ECT INFO

Length \_\_\_\_\_ Length of convulsion \_\_\_\_\_

### PCP COMMUNICATION

Has information been shared with the PCP regarding Behavioral Health Provider Contact Information, Date of Initial Visit, Presenting Problem, Diagnosis, and Medications Prescribed (if applicable)?  
 PCP communication completed on \_\_\_\_\_  
**Via:**  Phone  Fax  Mail  
 Member refused by (Signature/Title) \_\_\_\_\_  
 Coordination of care with other behavioral health providers? \_\_\_\_\_  
 Has informed consent been obtained from patient/guardian? \_\_\_\_\_  
 Date of most recent psychiatric evaluation \_\_\_\_\_  
 Date of most recent physical examination and indication of an anesthesiology consult was completed \_\_\_\_\_

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**CURRENT PSYCHOTROPIC MEDICATIONS**

Name	Dosage	Frequency

**PSYCHIATRIC/MEDICAL HISTORY**

Please indicate current acute symptoms member is experiencing

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Please indicate any present or past history of medical problems including allergies, seizure history and member is pregnant

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**REASON FOR ECT NEED**

Please objectively define the reasons ECT is warranted including failed lower levels of care (including any medication trials):

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Please indicate what education about ECT has been provided to the family and which responsible party will transport patient to ECT appointments:

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**ECT OUTCOME**

Please indicate progress member has made to date with ECT treatment

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**ECT DISCONTINUATION**

Please objectively define when ECTs will be discontinued – what changes will have occurred

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Please indicate the plans for treatment and medication once ECT is completed

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Provider Name (please print) \_\_\_\_\_

Provider Signature \_\_\_\_\_ Date \_\_\_\_\_