FROM

sunflower health plan

SUBMIT TO:
Utilization Management Department
PHONE 1.844.518.9505 FAX 1.844.811.5380

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	❑	❑	❑	❑	❑
Assault/ Violent Behavior	❑	❑	❑	❑	❑
Suicidal	❑	❑	❑	❑	❑
Depressive Symptoms	❑	❑	❑	❑	❑
Psychotic Symptoms	❑	❑	❑	❑	❑
Manic Symptoms	❑	❑	❑	❑	❑

*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

____

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

____

REASON FOR ECT NEED

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

____

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

____

ECT OUTCOME

Please indicate progress member has made to date with ECT treatment

____

ECT DISCONTINUATION

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

____

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

____

Provider Name (please print)______________________________

Provider Signature______________________________ Date______________

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