



## ELECTROCONVULSIVE THERAPY (ECT) AUTHORIZATION REQUEST FORM

Please print clearly – incomplete or illegible forms will delay processing.

### DEMOGRAPHICS

Patient Name \_\_\_\_\_

DOB \_\_\_\_\_

SSN \_\_\_\_\_

Patient ID \_\_\_\_\_

Last Auth # \_\_\_\_\_

### PREVIOUS BH/SUD TREATMENT

None or  OP  MH  SUD and/or  IP  MH  SUD

List names and dates, include hospitalizations \_\_\_\_\_

Substance Abuse  None  By History and/or  Current/Active

Substance(s) used, amount, frequency and last used \_\_\_\_\_

### CURRENT ICD DIAGNOSIS

Primary \_\_\_\_\_

R/O \_\_\_\_\_ R/O \_\_\_\_\_

Secondary \_\_\_\_\_

Tertiary \_\_\_\_\_

Additional \_\_\_\_\_

Additional \_\_\_\_\_

### CURRENT RISK/LETHALITY

	1 NONE	2 LOW	3 MOD*	4 HIGH*	5 EXTREME*
Suicidal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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"/>
Psychotic 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) \_\_\_\_\_

Professional Credential: MD PhD Other \_\_\_\_\_

Provider TPI/NPI # \_\_\_\_\_

Provider Tax ID # \_\_\_\_\_

Hospital where ECT will be performed \_\_\_\_\_

Physical Address \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Hospital TPI/NPI # \_\_\_\_\_

Hospital 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 \_\_\_\_\_

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 \_\_\_\_\_

**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 if 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 occurred \_\_\_\_\_  
\_\_\_\_\_

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

**STANDARD REVIEW:**

Standard 14-day time frame will be applied.

**EXPEDITED REVIEW:**

By signing below, I certify that applying the standard 14-day time frame could seriously jeopardize the member's health, life or ability to regain maximum function.

\_\_\_\_\_  
Clinician Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Clinician Signature

\_\_\_\_\_  
Date

SUBMIT TO  
**Utilization Management Department**  
Phone: 866-329-4701 Fax: 844-528-3453