New Avenues
Maximizing Human Productivity and Well-Being
MIDWEST BEHAVIORAL HEALTH NETWORK
P.O. Box 360, South Bend, IN 46624 · Phone: (866) 925 - 5730 · Fax: (574) 271 – 5980

REQUEST FOR ECT TREATMENT

Provider Name	_____	**Date of Request** _____
Facility/Organization	_____	**Phone:**_____ **Fax:** _____
Patient Name	_____	**DOB**_____
Health Plan	_____	**ID/SSN**_____
ECT REQUEST		
	□ INITIAL □ CONTINUING □ MAINTENANCE	**□INPATIENT □OUTPATIENT**
Number Of ECT Treatments For This Episode Of Care Given To Date_____	**NUMBER OF ECT SESSIONS REQUESTED**_____ **FREQUENCY**_____ **START DATE FOR THIS REQUEST** _____	**TYPE:** **□UNILATERAL** **□BILATERAL** **□UNSPECIFIED**
CLINICAL STATUS		
DIAGNOSIS	**AXIS I** _____ **AXIS II** _____ **AXIS III** _____ **AXIS IV** _____ **AXIS V GAF** _____	
SYMPTOMS /HIGH RISK Suicidality:	**□ Not Present □ Ideation □ Plan □ Means □ Prior Attempt**	
Homicidality	**□ Not Present □ Ideation □ Plan □ Means □ Prior Attempt**	
Mood Disturbance	**□Depression □Bipolar □Manic □Hypomania □Other**	
Other	**□Dementia Or Other Cognitive Deficits**	**□Substance Abuse Co-morbid**
Hallucinations	**□Auditory □Visual □Command □Other**	**□Delusions** **□Paranoid Thinking**
Functional Impairment	***DESCRIBE***	
Current Medications	***LIST CURRENT MEDS:***	
HISTORY		
Treatment **List prior treatments** **Please describe history**	**□Prior Inpatient Hospitalizations** **□Outpatient** **□ECT** ***How many total sessions were performed for pt. to reach maximal benefit?*** ____ **□Other** **□Medications**	
Describe Compliance And Response to Prior /Alternative Treatment: **Give rationale for the ECT at this time.** **If concurrent review, what is percentage of improvement in patient's condition since last treatment based on patient's perception? Provider's perceptions?**		
SIGNED BY **DATE**		