

ECT REFERRAL FORM

REFERRING FACILITY INFORMATION:

NAME OF FACILITY / CLINICIAN: _____

PHONE: _____ FAX: _____

EMAIL: _____

PATIENT INFORMATION:

NAME: _____ DATE OF BIRTH _____

ADDRESS: _____

PHONE: _____ EMAIL: _____

CLINICAL INFORMATION:

DIAGNOSIS: _____

DOES THIS PATIENT HAVE A PERSONALITY DISORDER OR CLUSTER TRAITS?

**WHY IS ECT BEING
RECOMENDED?**

**WHAT MEDICATION TRIALS HAVE BEEN TRIED AND WHY DID THEY FAIL? (i.e.
noncompliance,intolerance,ineffectiveness):**

PSYCHIATRIC PROVIDER: _____ **PHONE:** _____



Northern Arizona Healthcare
1200 N. Beaver Street, Flagstaff Arizona 86001



BHU

ECT REFERRAL FORM

DP-2314 (06/18)

PATIENT LABEL

FMC BH/Outpatient/ECT DCC 6/13/18

WHO WILL BE PROVIDING PSYCHIATRIC FOLLOW UP FOR THIS PATIENT DURING
OUTPATIENT ECT _____

HAS THIS PATIENT HAD ECT TREATMENT IN THE PAST? IF SO WHEN AND
WHERE: _____

MEDICAL HISTORY: (past and current conditions. Is there dementia, delirium, parkinsonism,
seizure history? Are they on anticonvulsants? Is there a thyroid or cardiac history?)

CURRENT MEDICATIONS:

ALLERGIES: _____

SUBSTANCE ABUSE HISTORY (past and current alcohol and drug use, first and last use,
frequency and amounts, past treatment):

RISK FACTORS:

VEGETATIVE
DEPRESSION: _____

CATATONIA: _____

MANIA: _____

SCHIZOPHRENIA
EXACERBATION: _____

ACTIVELY
SUICIDAL: _____



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