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

PATIENT LABEL

BHU

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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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