5515 PEACH STREET •ERIE, PENNSYLVANIA 16509 (814) 864-4031

Electroconvulsive Therapy Referral Process

Dear Patient,

Thank you for you and your patient's interest in Electroconvulsive Therapy (ECT). To help the referral process proceed as quickly and smoothly as possible please include all of the information requested below and complete the following form in its entirety.
Please include the following information:

*Demographic sheet/face sheet for the patient

*Physician's reason for referral

*Current medication list

*Recent (within the past 2 months) H&P

*Any diagnostic tests completed within the past 3 months

Please fax all completed referrals to 814-868-7659 Attention Mimi.

If you have any questions or concerns when completing the referral process please contact Mimi Wilwohl @814-868-7657 or mwilwohl@MCH1.org.

Once a completed referral is received, it will be reviewed by Millcreek Community Hospital's ECT attending, Dr. Mark Strazisar. If an ECT consult is deemed appropriate, the patient will be contacted to set up a consultation appointment. All consults take place at LECOM Institute for Behavioral Health, 4740 Peach Street. Supports to the patient are welcome to attend the consult. If ECT deemed inappropriate or not in the patient's best interest the referring physician's office will be contacted and made aware.

L|E|C|O|M HEALTH
MILLCREEK COMMUNITY HOSPITAL
5515 PEACH STREET •ERIE, PENNSYLVANIA 16509 (814) 864-4031

ECT Outpatient Consult

****ALL SECTIONS OF THIS FORM MUST BE COMPLETED****

Today's Date: ____________________

Referral Contact: ____________________________

Patient Name: _______________________________

Age: _______ DOB: _______________ Social Security #: __________________ Phone #: __________________

Address: ____________________________________ City: ______________ Zip: ______________

Emergency Contact: ___________________________ Relationship: _______________ Phone: ___________________

Referring Physician: ___________________________ Referring Physician Phone #: _____________________

Reason for Referral: ____

Primary Care Physician: ________________________

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Primary Insurance: ____________________________ Primary Insurance ID: __________________________

Secondary Insurance: __________________________ Secondary Insurance ID: ________________________

Insurance Company Phone #: ___________________ Person spoke with: ____________________________

Primary Insurance Auth #:_______________________ Secondary Insurance Auth #: ____________________

Authorization CPT #: **__90792_** ICD-10 Diagnosis: _____________________________

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Patient **CURRENT** Medication List

Medication Name	Dose	Route/Schedule

Latex Allergy: Yes _______ No_______ Other Allergies: ____

*****Fax must also include****: Labs, Radiology, EEG, Cardio Records, H&P, Last Progress Note**

Patient cannot be pregnant

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