

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 LECOM Medical Center'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.

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: _____

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: _____

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