New Avenues
Midwest Behavioral Health Network

MIDWEST BEHAVIORAL HEALTH NETWORK
P.O. Box 360, South Bend, IN 46624 · Phone: (866) 925 - 5730 · Fax: (574) 271 – 5980

# REQUEST FOR ECT TREATMENT

| | | | | | | |
|---|---|---|---|---|---|---|
| **Patient Name** | | **DOB** | | **Health Plan and ID #** | | |
| **Provider Name** | | **Phone** | | **Fax** | | |
| **Facility/Organization** | | **Request Date** | | **Authorization Start Date** | | |

## ECT REQUEST

| | | |
|---|---|---|
| □ Initial □ Continuing □ Maintenance | Type: □ Unilateral □ Bilateral □ Unspecified | Service Setting: □ Inpatient □ Outpatient |

| | | | | | |
|---|---|---|---|---|---|
| **# of ECT Treatments for This Episode of Care Given to Date** | | **# of ECT Sessions Requested** | | **Frequency of Treatments** | |

## CLINICAL STATUS

| | | | |
|---|---|---|---|
| **DIAGNOSIS** | **PRIMARY:** | **SECONDARY:** | |
| | **CO-MORBID ISSUES:** | | |

## SYMPTOMS /HIGH RISK

| | | | |
|---|---|---|---|
| **Suicidality** | □ Not Present □ Ideation □ Plan □ Means □ Prior Attempt | **Other** | □ Dementia Or Other Cognitive Deficits |
| **Homicidality** | □ Not Present □ Ideation □ Plan □ Means □ Prior Attempt | **Hallucinations** | □ Auditory □ Visual □ Command □ Delusions □ Paranoid Thinking □ Other |
| **Mood Disturbance** | □ Depression □ Bipolar □ Manic □ Hypomania □ Other | **Co-morbid** | □ Substance Abuse □ Other |

| | |
|---|---|
| **Functional Impairment** | ***DESCRIBE*** |
| **Current Medications** | ***LIST CURRENT MEDS:*** |

## HISTORY

| | | | | | |
|---|---|---|---|---|---|
| **Treatment List prior treatments** (Indicate history) | | | | | |
| **□ Prior Inpatient Hospitalizations** | ***How many prior Inpatient admissions*** | | **□ ECT** | ***How many total sessions were performed for pt. to reach maximal benefit?*** | |
| **□ Outpatient** | **□ Other** | **Medications** (list) | | | |

**Describe Compliance and Response to Prior / Alternative Treatment(s):** **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?**

| | | | |
|---|---|---|---|
| **PRINTE NAME:** | **SIGNATURE:** | **DATE SIGNED** | |