

SUBMIT TO:

Utilization Management Department
 12515-8 Research Blvd., Suite 400
 Austin, Texas 78759
 PHONE 1.877.617.0390
 FAX 1.866.279.1358

ELECTROCONVULSIVE THERAPY (ECT) Authorization Request Form

***All Fields Must Be Completed For This Request To Be Reviewed. Please type or print neatly.**

Please indicate which level of care the member is currently engaged: INPATIENT OUTPATIENT

DEMOGRAPHICS

Patient Name _____
 Patient Last Name _____
 DOB _____
 SSN _____
 Patient ID _____
 Last Auth # _____

PROVIDER INFORMATION

Provider Name (print) _____
 Hospital where ECT will be performed _____
 Professional Credential: MD PhD Other _____
 Physical Address _____
 Phone _____ Fax _____
 TPI/NPI # _____ Tax ID # _____

PREVIOUS BH/SA TREATMENT

None or OP MH SA and/or IP MH SA

List names and dates, include hospitalizations _____

Substance Use None By History and/or Current/Active

Substance(s) used, amount, frequency and last used _____

Current ICD Diagnosis

Primary (Required) _____
 Secondary _____
 Tertiary _____
 Additional _____
 Additional _____

CURRENT RISK/LETHALITY

	1 NONE	2 LOW	3 MOD*	4 HIGH*	5 EXTREME*
Homicidal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assault/ Violent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychotic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*3, 4, or 5 please describe what safety precautions are in place

REQUESTED AUTHORIZATION FOR ECT

Please indicate type(s) of service provided by YOU and the frequency.

Total sessions requested _____

Type Bilateral _____ Unilateral _____

Frequency _____

Date first ECT _____ Date last ECT _____

Est. # of ECTs to complete treatment _____

Requested start date for authorization _____

LAST ECT INFO

Length _____ Length of convulsion _____

PCP COMMUNICATION

Has information been shared with the PCP regarding Behavioral Health Provider Contact Information, Date of Initial Visit, Presenting Problem, Diagnosis, and Medications Prescribed (if applicable)?

PCP communication completed on _____

Via: Phone Fax Mail

Member refused by (Signature/Title) _____

Coordination of care with other behavioral health providers? _____

Has informed consent been obtained from patient/guardian? _____

Date of most recent psychiatric evaluation _____

Date of most recent physical examination and indication of an anesthesiology consult was completed _____

SUBMIT TO:

Utilization Management Department

12515-8 Research Blvd., Suite 400

Austin, Texas 78759

PHONE 1.877.617.0390

FAX 1.866.279.1358

CURRENT PSYCHOTROPIC MEDICATIONS

Name	Dosage	Frequency

PSYCHIATRIC/MEDICAL HISTORY

Please indicate current acute symptoms member is experiencing

Please indicate any present or past history of medical problems including allergies, seizure history and member is pregnant

REASON FOR ECT NEED

Please objectively define the reasons ECT is warranted including failed lower levels of care (including any medication trials):

Please indicate what education about ECT has been provided to the family and which responsible party will transport patient to ECT appointments:

ECT OUTCOME

Please indicate progress member has made to date with ECT treatment

ECT DISCONTINUATION

Please objectively define when ECTs will be discontinued – what changes will have occurred

Please indicate the plans for treatment and medication once ECT is completed

Provider Name (please print) _____

Provider Signature _____ Date _____