

Electroconvulsive Therapy Continuation Request

Name of Person Completing this Form: _____

Phone #: _____ Fax #: _____

CBA must have the following information to process the request:

Patient Name: _____

ID Card #: _____ Date of Birth: _____

 Address Where Services are Rendered: _____

Name of Treating ECT Physician: _____

Treating ECT Physician's NPI: _____

Name of Attending Physician: _____

Attending Physician's NPI: _____

 Current Medications: No Change New Medications: _____

Total number of treatments given in this series: _____

Number of treatments requested: _____

Frequency of treatments: _____

 Electrode Placement: Unilateral Bilateral Bifrontal Other: _____

Adverse effects of/events during ECT: _____

Current Clinical Assessment as of: _____

(Date)

 Definitions: **Mild:** Once/week or less. **Moderate:** Multiple events every week. **Severe:** Daily frequency of events or greater.

	None	Mild	Moderate	Severe
Self-Harm				
Other Harm				
Energy Impairment				
Hallucinations				
Appetite Changes				
Sleep				
Depression				
Crying Spells				
Somatic Complaints				
Ability to Function:				
Home/Family				
Work/School				
Other Symptoms (specify)				

Instead of completing the above clinical assessment, a commonly accepted rating scale such as the Beck Depression Inventory, Hamilton Depression Rating Scale or other clinician or self-rating scales may be attached.

Please make additional copies of this form for your office use. Thank you.