Magellan HEALTHCARE SM

Initial ECT Request Form
Fax to Magellan: 1.888.656-4916

Form to be completed by the MD who will administer ECT

Today's Date: _____ Requesting MD Name: _____

Contact Phone number: _____ MIS # for Authorization: _____

Member Name: _____ Medicaid ID Number: _____

Current Diagnosis: – *DSM (current version):*

_____

_____

_____

Mental Status:

Is member currently a danger to self? ☐ Yes ☐ No If yes, explain: _____

Is member currently a danger to others? ☐ Yes ☐ No If yes, explain: _____

Does member have a thought process disorder? ☐ Yes ☐ No If yes, explain: _____

Has member had past suicide attempts? ☐ Yes ☐ No If yes, explain: _____

Reason(s) for ECT Request – *Indicate ALL that apply:*

☐ Urgent need for a rapid response due to severity of illness and/or medical condition
☐ Lack of response or demonstrated intolerance to treatment alternatives
☐ Deterioration in member's condition despite active intensive treatment, including psychosocial interventions
☐ Severe impairment as measured by symptom severity, level of functioning and lethality
☐ Psychotic depression
☐ Acute mania
☐ Catatonia
☐ Severe suicidal ideation Explain: _____
☐ Depression, medications contraindicated (pregnancy, medical issue) Explain: _____

_____

Current Medications:

Name of Medication	Dose	Frequency	Prescribing Clinician

Past Medication Trials – *List all known past medications with dose, frequency and prescribing clinician when available:*

Medication Issues – *Select all that apply and describe*

☐ Side Effects: _____

☐ Treatment Resistance: _____

☐ Substance Abuse: _____

☐ Noncompliance: _____

☐ Other: _____

Why is ECT preferable to medications? _____

Other relevant medical information: _____

Was member referred to ECT by another psychiatrist? ☐ Yes ☐ No

If yes, name of referring psychiatrist: _____ **Phone #:** _____

Has member had past ECT treatments? ☐ Yes ☐ No If yes, please list dates and outcomes/response to treatment:

_____

_____

Can ECT be on an ambulatory basis? ☐ Yes ☐ No **If no, please explain:**

_____

Contraindications and/or Risk Factors Present - *Please select <u>ALL</u> that apply*

☐ Intracranial Mass ☐ Musculoskeletal injury or abnormality ☐ Acute or Impending Retinal Detachment

☐ Glaucoma ☐ Member is age 65 or older ☐ Advanced Pregnancy *(requires obstetric consult)*

☐ Severe Hypertension ☐ Pulmonary insufficiency ☐ Recent Myocardial Infarction *(requires cardiology consult)*

☐ Anesthetic Risk ☐ Severe osteoporosis ☐ Cardiac Arrhythmia *(requires cardiology consult)*

☐ Recent CVA/Bleed ☐ History of sever character disorder with predominately chronic dysthymia

☐ Other: _____

Current Medical Conditions:

_____

_____

Procedures required for ECT – *Indicate who will perform each procedure and the date performed*

Procedure:	**Performed by:**	**Date Performed:**
☐ Review of Psychiatric and Medical History		
☐ Physical and Psychiatric Exam		
☐ Medical Clearance		
☐ Anesthetic Clearance		
☐ Additional Procedures Needed to Assess/Monitor Risk		
☐ Mental status examination		
☐ Signed Informed Consent		
☐ Serum Electrolytes		
☐ EKG		
☐ Urinalysis		
☐ CBC (Blood Work)		

Treatment Coordination – *Indicate name on the line provided*

Have you communicated with the primary care physician? ☐ Yes ☐ No ☐ N/A _____

Have you communicated with other treatment providers? ☐ Yes ☐ No ☐ N/A _____

Clinical Summary – *Include current symptoms and pertinent past psychiatric history*

The individual and/or legal guardian is able to understand the purpose, risks and benefits of ECT and provides consent.
☐ Yes ☐ No

Number of ECT Treatments Being Requested: _____

Expected Date of Initial Treatment: _____

Expected Dates of Subsequent Treatments: _____

I verify that the information provided within this report is an accurate representation of the member's status and that I am privileged to administer this procedure.

Physician Signature: _____ Date: _____