Companion
BENEFIT ALTERNATIVES

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# Electroconvulsive Therapy Initiation Request

Name of person completing form: _____

Phone Number: _____ Fax Number: _____

**CBA must have the following information to process the request:**

Patient's Name: _____ Diagnosis: _____
Date of Birth: _____
ID Card Number: _____ Axis I: _____
Name of Requesting MD: _____ Axis II: _____
Requesting MD's NPI: _____ Axis III: _____
Facility's Name: _____ Axis IV: _____
Facility's NPI: _____ Axis V: _____
MD Performing ECT (if different): _____
Address Where Services are Rendered: _____

Treatment History (Include both outpatient and inpatient with dates, locations and lengths of stay):

_____
_____
_____
_____
_____

Has a current Medical Assessment been completed? Yes ☐ No ☐
Has a current Psychiatric Assessment with a Cognitive Component been completed? Yes ☐ No ☐

Medication History: (List All Past Medications and Current Medications)

| Past Medication | Dose | Duration of Rx | Response | Current Medication |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

List any prior ECT Series and Outcomes the patient experienced (include dates and locations):

_____
_____
_____

Why is the patient being referred for ECT at this time?

_____
_____
_____

How many treatments/what frequency are you requesting? _____
What is the projected ECT start date? _____

***Certification is Not Valid Until CBA Issues a Certification Number.***

**Office Use Only: Number of Visits Approved:** _____ **Date Range:** _____
**Authorization Number:** _____ **Reviewer:** _____ **Ext.:** _____

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