Companion BENEFIT ALTERNATIVES

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Electroconvulsive Therapy Continuation Request

Name of person completing this form: _____

Phone Number: _____ Fax Number: _____

CBA must have the following information to process the request:

Patient Name: _____

ID Card Number: _____ 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, you may attach a commonly accepted rating scale, such as the Beck Depression Inventory, Hamilton Depression Rating Scale or other clinician or self-rating scale.

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