SUBMIT TO
Utilization Management Department
1145 Broadway, Suite 700
Tacoma, WA 98402
PHONE: 1.877.644.4613
FAX 1-833-286-1086

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 # ____

PREVIOUS BH/SUD TREATMENT

None or OP MH SUD 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 ____

Teritary ____

Additional ____

Additional ____

CURRENT RISK/LETHALITY

	1 NONE	2 LOW	3 MOD*	4 HIGH*	5 EXTREME*
Homicidal					
Assault/ Violent					
Behavior					
Psychotic					
Symptoms					

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

____

____

PROVIDER INFORMATION

Provider Name (print) ____

Hospital where ECT will be performed ______________________________________

Professional Credential: MD PhD Other ____________________

Physical Address ____

Phone ___________________________ Fax _______________________________

TPI/NPI# ___________________________ Tax ID __________________________

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 ____

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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 if 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 occured ____

____

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

____

Provider Name (please print) ____

Provider Signature ____ Date ____________________________

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