



# BEHAVIORAL HEALTH SYSTEMS

Behavioral Healthcare Programs for Business & Industry Since 1989

## ECT Authorization Request

### PATIENT INFORMATION

Name: \_\_\_\_\_ Insured's ID Number: \_\_\_\_\_

### **DSM-IV-TR Diagnosis:**

Axis I \_\_\_\_\_ Axis IV \_\_\_\_\_  
Axis II \_\_\_\_\_ Axis V \_\_\_\_\_  
Axis III \_\_\_\_\_

**Prior ECT:** Yes  No

**Medication Resistant:** Yes  No

**Current Medications:** Yes  No

If yes, list medication(s) and dose:

1) \_\_\_\_\_ 3) \_\_\_\_\_  
2) \_\_\_\_\_ 4) \_\_\_\_\_

**Referring Physician:** \_\_\_\_\_ **Specialty:** \_\_\_\_\_

### ECT PROVIDER INFORMATION

Facility Name: \_\_\_\_\_ Primary Contact: \_\_\_\_\_  
Physician: \_\_\_\_\_  
Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

### ECT AUTHORIZATION REQUEST (Check one box only)

**Initial ECT**  **Continued ECT**  **Maintenance ECT**

ECT Start Date: \_\_\_/\_\_\_/\_\_\_ Number of Treatments Received to Date: \_\_\_\_\_  
Number of Treatments Requested with this Authorization: \_\_\_\_\_ Frequency: \_\_\_\_\_  
Anticipated Total Number of Treatments: \_\_\_\_\_

**If continued ECT**, provide a brief summary of patient response to recent ECT and rationale for continuation: \_\_\_\_\_  
\_\_\_\_\_

**If maintenance ECT**, treatment period covers \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

### ECT TREATMENT SETTING

Inpatient  Outpatient

**If inpatient**, indicate the primary clinical justification below. Indicated reason must be supported by submitted medical record documentation:

Imminent Dangerousness  Medical Risk/Complications   
Psychiatric Symptom Severity  Functional Impairment   
Other

\_\_\_\_\_  
**Physician Signature**

\_\_\_\_\_  
**Date**

**Please fax completed form to BHS Clinical Services at (205) 879-1178**