Electroconvulsive Therapy (ECT) Request Form

The attending physician/treating provider must complete this form. This form must be completed electronically, printed and faxed. No handwritten forms will be accepted. Please fax the completed form to 570-214-4539. If you have questions regarding this form, please call 888-839-7972.

Member's name: Date of birth:

Member's Health Plan ID: Telephone:

Treatment start date:

Requesting provider's name:

NPI:

Telephone: Fax:

Contact name: Contact telephone:

Contact fax:

ECT provider/facility name:

Servicing provider/facility NPI:

Telephone: Contact name:

Contact phone: Fax:

Current or provisional diagnoses:

1.	
2.	
3.	
4.	
5.	

Communication with outpatient provider

Did communication with outpatient provider occur?

- ○ Yes
- ○ No – please discuss with outpatient provider before submitting this form

Document communication between ECT provider and outpatient prescriber:

Communication with PCP

Name: Telephone:

Comments:

RATIONALE FOR REQUESTING ECT

What is the rationale for requesting ECT (e.g., failure of adequate trials of antidepressants, specific psychiatric or physical condition, unable to tolerate medication side-effects, etc.)? Provide the following specific details:

Level of severity of current episode:

○ Severe ○ Moderate, as evidenced by the following symptoms/behaviors:

Symptom	Severity (describe)	Duration
Depression		
Mania		
Psychosis		

Catatonia		
Agitation		
Energy		
ADLs		
Other		

Co-morbid issues, such as Axis II or substance abuse (describe):

Prior pharmacologic failures (identify when used simultaneously):

Medication/max dose	Year	Duration	Reason for failure

Prior hospitalizations:

Facility/city	Month/year	Reason

Current outpatient treatment:

Provider/city	Dates	Services

Prior ECT treatment;

Provider/city	Dates	Services

Has member been compliant with past medication treatment?

- ○ Yes
- ○ No – please describe

Does member have co-morbid medical conditions or severe side effects that prevent appropriate psychiatric medication treatment?

- ○ No
- ○ Yes – please describe

If the member is pregnant, does the risk of non-treatment outweigh the risk of ECT?

- ○ No
- ○ Yes – please provide results of consult

PSYCHIATRIC AND MEDICAL EVALUATION/EXAMINATION

Please attach copies of the following supporting documents:

- Current admission psychiatric evaluation (no older than 7 days), including mini mental status exam
- Current medical history and physical (no older than 7 days)
- Current urine drug screen results

INFORMED CONSENT

Has the member and family been educated and given informed consent for ECT?

- ○ Yes – attach copy of signed consent
- ○ No – explain

CURRENT MEDICATIONS (MEDICAL AND PSYCHIATRIC)

Medication contraindications – If member is antihypertensive with a beta blocker or calcium channel blocker, change medication to ACE inhibitor or diuretic. Aminophylline or theophylline should not be prescribed. Anticonvulsants should be used with caution, as they complicate ECT.

Medication/dose	Reason	Duration of use

NEED FOR INPATIENT STAY DURING ECT

Please identify any of the following conditions that make inpatient hospitalization necessary for ECT:

- ☐ Co-morbid medical conditions, making ECT without intensive monitoring unsafe
- ☐ Lack of social support or transportation to and from sessions
- ☐ Severity of symptoms
- ☐ Member unable to comply with post-procedure instructions (explain)

INTENSITY OF SERVICE

The following requirements must me met to approve an ECT request. Geisinger Health Plan reserves the right to request and review the following protocols:

- Anesthesia evaluation performed by an anesthesiologist or other qualified anesthesiology professional
- A medically necessary and appropriate individualized treatment plan or its update, specific to the member's psychiatric and/or medical conditions
- Continuous physiologic monitoring during ECT treatment
- Monitoring for and management of adverse effects during the procedure
- Post-ECT stabilization and recovery services

FOLLOW-UP PLAN

If member is inpatient, how long is hospitalization expected to continue?

For outpatient ECT request (or after discharge from inpatient ECT), identify who will be responsible for the individual.

What other services will be needed after completion of the ECT course/discharge?