Kern Medical
1700 Mount Vernon Avenue
Bakersfield, CA 93306
Fax: 661-321-7461
P: 661-862-7341

Electroconvulsive Therapy Referral Form

Patient Name (Last Name, First Name, Middle Initial)		Date
Birth Sex ☐ Male ☐ Female	Patient preferred language for healthcare communication	
Date of Birth	Patient Home Phone Number	Patient Alternative Phone Number.
Patient Home Address		Email Address
Patient insurance company and plan(s)		Authorization Number (if available)
Insurance Member ID	Group #	
Emergency Contact Name	Emergency Contact Phone Number	

Referring Provider Information:

Referring Provider Name (Last Name, First Name, Middle Initial)	
Referring Provider Contact Telephone	Referring Provider Fax
Referring Provider Address	
Patient's Primary Care Provider (Last Name, First Name, Middle Initial)	

Thank you for your interest in the Electroconvulsive Therapy for your patient at Kern Medical.

Patients are provided with an in-depth psychiatric evaluation for Electroconvulsive Therapy (ECT), including an extensive review of previous records, and treatment recommendations related to ECT. Patients are encouraged to bring a family member, care giver or a close friend with them to this consultation.

The ECT Consultation does not include prescription medications or follow-up care. Medications and follow-up care are provided by the referring physician only.

Inpatient Referral: For an inpatient bed request for ECT please call transfer coordinator at 661-326-2733, Fax 661-326-2687
For out-of-county referrals, an LPS conservatorship must be in place prior to the referral being sent.
Outpatient Referral: Fax referral form and information to: 661-321-7461, Attn: ECT Clinic. If you have any questions, please contact the Medical Assistant at 661-862-7341

Requested Procedure Information

How long have you known this patient?	Length of patient's current episode needing ECT?
Current Diagnosis/Diagnoses	
Current /Target Symptoms for ECT	

Past History of ECT ☐ No ☐ Yes If Yes, # of sessions: Type: ☐ UL ☐ BF ☐ BT Dates: Past Response: ☐ excellent ☐ good ☐ fair ☐ poor ☐ unknown	Past History of TMS ☐ No ☐ Yes If Yes, # of sessions: Dates: Past Response: ☐ excellent ☐ good ☐ fair ☐ poor ☐ unknown

Past History of Ketamine ☐ No ☐ Yes If Yes, ☐ IV Ketamine ☐ Nasal Ketamine
Past History of Substance Abuse ☐ No ☐ Yes ☐ In Remission ☐ Active Substance Use Please describe
Current Medication

Reason for ECT Referral

Please attach the last progress note, recent psychiatric evaluation note, insurance cards, demographics, any associated imaging.

Referring Physician Signature

Please fax referral form and records to 661-321-7461

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