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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