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.

In order to refer your patient:

1. Include a copy of the patient's insurance card (front and back)
2. Referral for outpatient ECT treatment from outpatient clinics or providers:
    a. If the patient is currently receiving outpatient psychiatric treatment: attach the initial psychiatric evaluation note, and clinical notes from the patients last two visits and summary of previous psychiatric medications or
    b. If the patient is currently receiving inpatient psychiatric treatment and being discharged: attach the initial inpatient psychiatric evaluation note, history and physical (H&P) note, inpatient progress notes from last seven days, medication administration record (MAR) during hospital stay AND outpatient records as mentioned above (section 2.a)
3. Referral for inpatient ECT treatment from an inpatient hospital or residential treatment center/placement:
    a. Attach the initial psychiatric evaluation note, history and physical (H&P) note, progress notes from last seven days, medication administration record (MAR) during stay AND all inpatient and outpatient records available
4. Attach all **treatment** or **testing** records
5. Attach a clinical Face Sheet with the patients demographics or complete the demographics section above
6. Fax referral form and information to: **661-321-7461**, Attn: ECT Clinic
    a. Please fax during business hours: 8:00am-4:30pm.
7. If you have any questions, please contact the Patient Care Coordinator **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 last progress note, history and physical, insurance cards, demographics, any associated imaging.

Referring Physician Signature

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

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