coordinated care™

SUBMIT TO
Utilization Management Department
1145 Broadway, Suite 300
Tacoma, WA 98402
PHONE: 1.877.644.4613
FAX 1-833-286-1086

ELECTROCONVULSIVE THERAPY (ECT) Authorization Request Form

*All Fields Must Be Completed For This Request To Be Reviewed. Please type or print neatly.

Please indicate which level of care the member is currently engaged: ❑ INPATIENT ❑ OUTPATIENT

DEMOGRAPHICS

Patient Name _____

Patient Last Name _____

DOB _____

SSN _____

Patient ID _____

Last Auth # _____

PREVIOUS BH/SUD TREATMENT

❑ None or ❑ OP ❑ MH ❑ SUD and/or ❑ IP ❑ MH ❑ SA

List names and dates, include hospitalizations _____

_____

Substance Use Disorder

❑ Substance Use ❑ None ❑ By History and/or ❑ Current/Active

Substance(s) used, amount, frequency and last used _____

_____

CURRENT ICD DIAGNOSIS

Primary (Required) _____

Secondary _____

Teritary _____

Additional _____

Additional _____

CURRENT RISK/LETHALITY

	1 NONE	2 LOW	3 MOD*	4 HIGH*	5 EXTREME*
Homicidal	❑	❑	❑	❑	❑
Assault/ Violent	❑	❑	❑	❑	❑
Behavior	❑	❑	❑	❑	❑
Psychotic	❑	❑	❑	❑	❑
Symptoms	❑	❑	❑	❑	❑

*3, 4, or 5 please describe what safety precautions are in place

_____

_____

PROVIDER INFORMATION

Provider Name (print) _____

Hospital where ECT will be performed _____

Professional Credential: ❑ MD ❑ PhD ❑ Other _____

Physical Address _____

Phone _____ Fax _____

TPI/NPI# _____ Tax ID _____

REQUESTED AUTHORIZATION FOR ECT

Please indicate type(s) of service provided by YOU and the frequency.

Total sessions requested _____

Type Bilateral _____ Unilateral _____

Frequency _____

Date first ECT _____ Date last ECT _____

Est. # of ECTs to complete treatment _____

LAST ECT INFO

Length _____ Length of convulsion _____

PCP COMMUNICATION

Has information been shared with the PCP regarding Behavioral Health Provider Contact Information, Date of Initial Visit, Presenting Problem, Diagnosis, and Medications Prescribed (if applicable)?

Via: ❑ Phone ❑ Fax ❑ Mail

❑ Member Refused by (Signature/Title) _____

Coordination of care with other behavioral health providers? _____

Has informed consent been obtained from patient/guardian? _____

Date of most recent psychiatric evaluation _____

Date of most recent physical examination and indication of an anesthesiology consult was completed _____

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CURRENT PSYCHOTROPIC MEDICATIONS

Name	Dosage	Frequency

PSYCHIATRIC/MEDICAL HISTORY

Please indicate current acute symptoms member is experiencing _____

_____

Please indicate any present or past history of medical problems including allergies, seizure history and if member is pregnant _____

_____

REASON FOR ECT NEED

Please objectively define the reasons ECT is warranted including failed lower levels of care (including any medication trials) _____

_____

Please indicate what education about ECT has been provided to the family and which responsible party will transport patient to ECT appointments _____

_____

_____

ECT OUTCOME

Please indicate progress member has made to date with ECT treatment _____

_____

ECT DISCONTINUATION

Please objectively define when ECTs will be discontinued – what changes will have occurred _____

_____

Please indicate the plans for treatment and medication once ECT is completed _____

_____

Provider Name (please print) _____

Provider Signature _____ Date _____