Texas Tech Physicians

Electroconvulsive Therapy (ECT) Referral

Patient Name:	Referral Date:
Patient DOB:	Patient Phone #:
Referring Provider:	Provider Ph. # Fax #:
Insurance name and address:	

Note:

ECT is a specialized procedure for many psychiatric issues (depression, catatonia, mania and psychosis) and especially effective for depression. Patients who meet criteria for ECT will potentially receive treatments for months but are required to have ongoing engagement and medication management with their primary/referring provider.

During ECT treatment, will you continue to follow the patient and provide him/her with psychiatric treatment and medication management?

☐ **YES** ☐ **NO** if you select NO, please provide reason/reasons:

Reason for ECT Referral/Evaluation(What was the patient told about the referral?)

Please estimate allowable wait time (We do not provide emergency care):

- ☐ Can wait 8 weeks or more
- ☐ Should be seen in 4 to 8 weeks (We will attempt but cannot guarantee an appointment)

What therapy interventions have been attempted?

- ☐ None
- ☐ Individual / Family Therapy (please provide the therapist's name)
- ☐ Psychotropic Medications trials in the past(Please specify):
- ☐ Psychiatric Inpatient / Residential Care

Please list any current psychiatric medications and dosages:

Please specify if the patient is currently suffering significant medical, cardiac and/or neurological problems:

Please provide the most recent lab work, EKG and progress note.

Race/Ethnicity/Preferred Language:

OTHER PERTINENT INFORMATION:

For the clinic use only:

The patient is accepted; please schedule an appointment within ☐ 2- 4 weeks ☐ 4-8 weeks ☐ 8-12 weeks ☐ 12-24 weeks.

The patient may see by (Resident/ Mid-level trainee).

The patient does not meet current criteria to be seen in our clinic for the following reason(s):