REQUEST FOR OUTPATIENT ECT/TMS

Please fax to: Behavioral Health Services Toll Free: 1.866.616.6255

All sections must be completed for timely approval

Member Name: _____

Member ID: _____ Date of Birth: _____

Provider Name: _____

Provider Phone Number: _____ NPI #: _____

Provider Address: _____

_____

Location of Treatment: _____

Diagnosis (ICD-10): _____

Number of treatments requested: _____ Timeframe requested: _____

REQUEST FOR ECT TREATMENT:	REQUEST FOR TMS TREATMENT:
☐ Initial ☐ Continuation ☐ Maintenance	☐ Initial ☐ Continuation

Symptoms:

Depression	☐ Yes	☐ No	Neuroleptic malignant syndrome	☐ Yes	☐ No
Suicidal ideations	☐ Yes	☐ No	Acute or chronic psychosis	☐ Yes	☐ No
Suicidal intent	☐ Yes	☐ No	Dementia	☐ Yes	☐ No
Delusions	☐ Yes	☐ No	Seizure disorder	☐ Yes	☐ No
Hallucinations	☐ Yes	☐ No	Substance use disorder	☐ Yes	☐ No
Disorganized thinking/speech	☐ Yes	☐ No	Other symptoms:	☐ Yes	☐ No
Racing thoughts	☐ Yes	☐ No			
Flight of ideas	☐ Yes	☐ No			
Catatonia not due to a medical condition	☐ Yes	☐ No	History of non-compliance to treatment	☐ Yes	☐ No

TREATMENT HISTORY (ALL TREATMENT):	
Last ECT treatment:	Last TMS Treatment:

DESCRIBE CURRENT/PAST MEDICATION TRIALS:

DESCRIBE CURRENT/PAST SUPPORTIVE MEDICAL TREATMENT:

ECT/TMS HISTORY AND RESPONSE:

OTHER TREATMENTS:
Implanted or embedded magnetic – sensitive metals in member head or neck ☐ Yes ☐ No Informed consent obtained ☐ Yes ☐ No

PRE-ECT WORKUP:	
Completed ☐ Yes ☐ No	Clearance given ☐ Yes ☐ No
Additional information, if applicable:	

Requested by: _____ Date: _____

REVIEWED 08/23/2018

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