# 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:**

| Symptom | | | Symptom | | |
|---|---|---|---|---|---|
| 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

1110 Main Street, Wheeling, WV 26003-2704 • P: 1.800.624.6961

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