ECT REFERRAL FORM

Send completed form to:

Email: patients@matthewbergermd.com **| Fax: (570) 207-0615**

Offices of Psychiatry & Counseling Services
Matthew A. Berger, MD, PC

REFERRAL SOURCE INFORMATION

Provider: | NPI: | Phone: | Fax:

Practice: | Address: | Email:

PATIENT INFORMATION

Patient: | Age: | DOB: MM DD YYYY

Address: | Phone:

Gender: ☐ Female ☐ Male **INSURANCE:** Primary: | Secondary:

Current diagnosis code:

Current medications:

SCREENING QUESTIONS

Please check any of the following (check all that apply):

☐ Anesthesia complications ☐ Seizure disorder ☐ Cardiac disease/HTN

☐ Substance abuse ☐ Back/neck problems or surgeries ☐ Aneurysmal disease

☐ Pregnant and/or breastfeeding ☐ Head injury/Brain bleed ☐ Current/previous substance use/abuse

Is the patient currently taking any mood stabilizers or seizure medications? ☐ Yes ☐ No

Examples: Lithium, Lamictal, Trileptal, Tegretol, Gabapentin, Keppra, Topamax, Depakote, Phenytoin, Vimpat, Zonegran

Name/dose of medication:

Has the patient been advised that this medication will need to be held/stopped for ECT? ☐ Yes ☐ No

CLEARANCE ORDERS

Has an order for lab work for clearance been provided to the patient? ☐ Yes ☐ No

Labs ordered (check all that apply):

☐ CBC ☐ CMP ☐ TSH ☐ T4 Free ☐ T3 Uptake ☐ Urinalysis

Has an order for X-rays for clearance been provided to the patient? ☐ Yes ☐ No

Orders given (check all that apply):

☐ Chest - 2 views ☐ Cervical spine ☐ Thoracic spine ☐ Lumbosacral spine

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CLEARANCE ORDERS (CONTINUED)

Has an order for an EKG for clearance been provided to the patient? ☐ Yes ☐ No

☐ Order given: EKG

Has an order for medical clearance by the PCP been provided to the patient? ☐ Yes ☐ No

☐ Order given: Clearance for ECT evaluation

Has the patient been advised that medical clearance is required every 30 days to continue ECT in accordance with hospital policies? ☐ Yes ☐ No

HISTORY QUESTIONS

Has the patient been diagnosed with Major Depressive Disorder (moderate/severe) or Bipolar depression? ☐ Yes ☐ No

Other diagnosis:

LEVEL OF SEVERITY OF CURRENT DIAGNOSIS

Describe the current severity evidenced by each applicable symptom:

Depression - severity:

Mania - severity:

Psychosis - severity:

Catatonia - severity:

Agitation - severity:

Energy - severity:

ADLs - severity:

Other:

Was the diagnosis validated using a diagnostic tool (for example, PHQ-9)? ☐ Yes ☐ No

☐ PHQ-9 attached

Other tool used:

Is the patient currently taking an antidepressant? ☐ Yes ☐ No

Name/dose:

ALL other psychotropic medications tried (name/doses/results):

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CURRENT PROVIDERS

Patient's current psychiatric prescriber:

Therapist:

PAST TREATMENTS & RATIONALE FOR ECT

List past alternative trials or other treatments for depression and the rationale for requesting ECT:

☐ TMS Date: MM DD YYYY

Results:

☐ Ketamine Date: MM DD YYYY

Indication:

Results:

Failure of adequate trials of antidepressants:

Unable to tolerate psychotropic medications due to side effects:

Other:

PRIMARY CARE PROVIDER

Who is the patient's PCP, and will the patient consent to communication for medical clearance? ☐ Yes ☐ No

PCP name:

Address:

Phone number:

TRANSPORTATION

Does the patient have reliable transportation to and from the treatment facility? ☐ Yes ☐ No

Name:

Relationship of person providing transportation: