ECT SERVICES — CONSULTATION REFERRAL

PLEASE INCLUDE A COPY OF PATIENT'S INSURANCE CARD OR FACE SHEET WITH INSURANCE INFORMATION

Date of referral ____________________

IMPORTANT: ***To proceed with your referral, we must have patient's insurance information, as ASTBH facility may be out of network. Please fax a copy of patient's insurance card or send copy of face sheet with insurance information to (629) 228-7951. Once we receive your referral and verify insurance benefits, we will contact your patient to schedule a consultation or inform you if we are unable to schedule a consultation for any reason.***	
Patient Name:	Date of Birth:
Diagnoses:	Primary Contact Phone Number:

Antidepressant medication tried during current episode:	Check if patient currently taking:	Duration:	Maximum dose tried:	Augmentation agent used with this medication:	Check if patient currently taking:	Response (positive and/or negative — list any rating scales used, such as PHQ-9, GAD-7, BDI):

Other psychiatric medications tried during current episode:	Check if patient currently taking:	Maximum dose tried:	Duration:	Response (positive and/or negative — list any rating scales used, such as PHQ-9, GAD-7, BDI):
Psychotherapy (specify type of therapy, i.e., CBT, DBT, PHP):		**Session frequency:**	**Duration in therapy:**	**Response (positive and/or negative — list any rating scales used, such as PHQ-9, GAD-7, BDI):**

Other Past Attempted Psychotropic Medication Trials

FAX BACK TO: (629) 228-7951

Additional Medical History

Additional Medical History	
Does patient have any metal in their body?	If yes, where?
Does patient have any cardiovascular or neurological conditions?	Please specify:

Psychiatric Hospitalizations

Hospital	When?	Reason?
Partial Hospitalization Program	**When?**	**Reason?**

Past Treatment	When?	Where?	Treatment parameters:	Response:
TMS				
ECT				
Other				

Currently Prescribed Nonpsychiatric Medications

Medication	Dose	Frequency
Please list current PCP:	Name:	Phone:

Please attach additional medication sheet if needed.

Referring Practitioner: *Must be signed by a physician, PA, or NP*

Name (Print):	Signature:
Date:	Time:

Note: Ascension Saint Thomas Behavioral Health Department of ECT functions as a consultation service. All primary psychiatric needs remain with the referring practitioner during and after any Ascension Saint Thomas Behavioral Health treatment.

FAX BACK TO: (629) 228-7951