SUBMIT TO

Utilization Management Department

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ELECTROCONVULSIVE THERAPY (ECT)

Please print clearly – incomplete or illegible forms will delay processing.

DEMOGRAPHICS

Patient Name: _____

Date of Birth: _____

Medicaid ID#: _____

Last Auth #: _____

PREVIOUS MH/SA TREATMENT

☐ None or ☐ OP ☐ MH ☐ SA and/or ☐ IP ☐ MH ☐ SA

List names and dates, include hospitalizations: _____

_____

Substance Use: ☐ None ☐ By History and/or ☐ Current/Active

Tobacco Use: ☐ None ☐ By History and/or ☐ Current/Active

Substance(s) used, amount, frequency and last used: _____

_____

Date of last Initial Diagnostic Interview (IDI): _____

Informed consent obtained from parent/guardian? ☐ Yes ☐ No

Pre-ECT workup complete and clearance obtained? ☐ Yes ☐ No

CURRENT ICD DIAGNOSIS

Primary: _____

Secondary: _____

Tertiary: _____

Additional: _____

Additional: _____

If the member has a substance use and/or HIV diagnosis, has a consent to release information for the related conditions been obtained?

☐ Yes ☐ No ☐ N/A

PRIMARY CARE PROVIDER (PCP) COMMUNICATION

Has the information been shared with the PCP regarding:

- The initial evaluation and treatment plan? ☐ Yes ☐ No
- This updated evaluation and treatment plan? ☐ Yes ☐ No

PCP name and date last notified: _____

If no, explain: _____

PROVIDER INFORMATION

Provider Name: _____

Professional Credential: ☐ MD ☐ PhD ☐ Other: _____

Address: _____

Phone: _____

Fax: _____

Facility NPI/TIN#: _____

Rendering Provider NPI/TIN#: _____

Please indicate to whom the authorization should be made:

☐ Individual Provider ☐ Group/ Facility

CURRENT RISK/ LETHALITY

	1 None	2 Low*	3 Mod*	4 High*	5 Extreme*
Suicidal	☐	☐	☐	☐	☐
Homicidal	☐	☐	☐	☐	☐
Assault/Violent Behavior	☐	☐	☐	☐	☐

*2-5 please describe what safety precautions are in place: _____

_____

_____

Please answer YES or NO to the following questions:

- Is the member currently participating in any community based support groups/ interventions? ☐ Yes ☐ No
- Has the member's Medical Psychiatric Evaluation been completed? ☐ Yes ☐ No
- Is the member's family/ supports involved in treatment? ☐ Yes ☐ No
- Coordination of care with other behavioral health providers? ☐ Yes ☐ No
- Coordination of care with medical providers? ☐ Yes ☐ No
- Has the member been evaluated by a Psychiatrist? ☐ Yes ☐ No
- Is this member currently receiving 1915(i) SPA, 1915(c), or 1915(b)(3) waiver services? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

CLINICAL INFORMATION

Has the member had trials of psych medication regimens? ☐ Yes ☐ No

If so, has the member had the most recent generation of medications and at adequate dosages? ☐ Yes ☐ No

Does the member have a comorbid medical condition in which prescribing psych meds would result in significant adverse effects? ☐ Yes ☐ No

List current and previous medications used by the member:

Is the member's condition too acute to continue on psych meds and wait for titration? ☐ Yes ☐ No

Is the member acutely suicidal, psychotic, depressed, manic? ☐ Yes ☐ No

What are the member's current symptoms? (socially withdrawn, decreased need for sleep, racing thoughts, severe agitation, etc.?)

Has the member given informed consent? ☐ Yes ☐ No

Has the member's personal and family medical/psychiatric history review been done? ☐ Yes ☐ No

Has a physical examination been performed on the member? ☐ Yes ☐ No

If so, are there any risk factors or signs of complications?

Has the member been (or will they be) evaluated by an anesthesia provider prior to the ECT treatments? ☐ Yes ☐ No

Has the member been evaluated by an ECT-privileged psychiatrist? ☐ Yes ☐ No

Has the member previously had ECT treatments? ☐ Yes ☐ No

If so, was it successful? ☐ Yes ☐ No

TREATMENT/ DISCHARGE GOALS

List the primary complaint/ problem to be addressed: _____

_____

List measurable treatment goals: _____

_____

Objectively describe how you will know the patient is ready to discontinue treatment: _____

_____

_____

CURRENT RISK/ LETHALITY

	Yes	No
Overall progress toward goal	☐	☐
Compliance with treatment	☐	☐
Medical Psychiatric Eval done? (even if PCP providing meds)	☐	☐

Medication given by? ☐ Psychiatrist ☐ PCP ☐ N/A

REQUESTED AUTHORIZATION

☐ 901 ECT

☐ 90870 ECT

Total sessions requested: _____

Frequency of Visits: _____

CPT Codes: _____

Estimated # of sessions to complete treatment episode: _____

Requested Start Date: _____

Requested End Date: _____

_____ _____ _____

Clinician Signature Clinician Name Date