SUBMIT TO
Utilization Management Department
5900 E. Ben White Blvd.
Austin, TX 78741
PHONE 1-844-842-2537 | FAX 1-866-900-6918

INPATIENT ELECTROCONVULSIVE THERAPY (ECT) REQUEST FORM

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: ______________________

TNI/NPI #: ______________________

Tax ID#: ______________________

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 has 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 all the medications that have been 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 treatment?	☐ 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

	1 None	2 Low*	3 Mod*	4 High*	5 Extreme*
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: ____________________

For applicable service requests, please include the following information and corresponding clinical documentation:

LOCUS/CASII Score _______ Intensity of Needs Level _______

____________________ ____________________ ____________________

Clinician Signature | Clinician Name | Date