CURRENT PSYCHOTROPIC MEDICATIONS

Name	Dosage	Frequency

PSYCHIATRIC/MEDICAL HISTORY

Please indicate current acute symptoms member is experiencing ______________________

____

Please indicate any present or past history of medical problems including allergies, seizure history and member is pregnant ______________________

____

REASON FOR ECT NEED

Please objectively define the reasons ECT is warranted including failed lower levels of care (including any medication trials) ______________________

____

Please indicate what education about ECT has been provided to the family and which responsible party will transport patient to ECT appointments

____

____

ECT OUTCOME

Please indicate progress member has made to date with ECT treatment ______________________

____

ECT DISCONTINUATION

Please objectively define when ECTs will be discontinued – what changes will have occured ______________________

____

Please indicate the plans for treatment and medication once ECT is completed ______________________

____

STANDARD REVIEW: Standard 14-day time frame will be applied.

____

Provider Name (please print) Date

EXPEDITED REVIEW: By signing below, I certify that applying the standard 14-day time frame could seriously jeopardize

____

Provider Name (please print) Date

SUBMIT TO
Utilization Management Department
5900 E. Ben White Blvd.
Austin, TX 78741
PHONE 1-844-842-2537 | FAX 1-855-772-7079