Date of Request:_____
Member's Name: _____ DOB:_____
Medicaid ID No:_____ Medicare ID No:_____

Physician Name and credenitals:_____

Hospital were ECT will be performed:_____

Address:_____

Phone No:_____ Fax No:_____

Total number of sessions requested:_____
Type: _____Bilateral _____ Unilateral
Frequency:_____
Estimate no. of ECTs to complete treatment:_____

Has the member had previous ECT?
_____Yes _____ No

If Yes, for each trial, list Dates, Place of Service (setting/protocols implemented) and describe member's response:

1. _____
   _____
   _____
2. _____
   _____
   _____
3. _____
   _____
   _____

Reason(s) for ECT Request – Indicate ALL that apply:

_____Urgent need for a rapid response due to severity of illness and/or medical condition
_____Lack of response or demonstrated intolerance to treatment alternatives
_____Deterioration in member's condition despite active intensive treatment, including psychosocial interventions
_____Severe impairment as measured by symptom severity, level of functioning and lethality
_____Psychotic depression
_____Acute mania
_____Catatonia
_____Severe suicidal ideation Explain:
_____
_____
_____Depression, medications contraindicated (pregnancy, medical issue) Explain:
_____
_____

Please indicate current acute symptoms: _____
_____
Please indicate any present or past history of medical problems including allergies, seizure history and if member is pregnant: _____
_____
What courses of medication have been tried and failed? And over what period of time, prior to requesting ECT? (include specific dates with specific doses of past medications)
_____
_____
_____
Please indicate if maintenance ECT will be requested: _____ Yes _____ No
If Yes, will it be inpatient or outpatient: _____

Please fax this completed form to DWMHA's UM Department at 313-833-3670

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ECT was: ☐ Approved ☐ Denied

If approved, number of sessions approved: _____

If denied, was the provider informed about the appeal rights and process: ☐ Yes ☐ No

Rational for Approval or Denial:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

_____ _____

Physician Signature Date