



Request for Electroconvulsive Therapy (ECT)
PM Form 3.14.9

Instructions: Please fax to NARBHA UM at 928-214-1166. It is necessary to include a treatment plan

Member Name:	Member ID:
AHCCCS ID:	Responsible Agency:
Facility Name:	Number of Days Requested:
Date of Admission:	Estimated Length of Stay (days):
Name of MD/NP/PA to contact for more information:	
MD phone/pager #:	
Requestor Name and Contact info:	Name of current therapist:

DIAGNOSIS: Axis I:	Axis II:	Axis III:
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Rationale for Requesting ECT:
Proposed physician and location for ECT:

Informed Request Y: <input type="checkbox"/> N: <input type="checkbox"/>

Current Medications with name, dose and frequency:
*Attach a list of medication trials / dates and outcome(s) to this request

Substance Use History:

Previous ECT History:

Physician Signature and date: _____