Request for Electroconvulsive Therapy (ECT)
PM Form 3.14.9

Instructions: Please fax to NARBHA UM at 928-214-1166. Psychiatric Evaluation, Treatment plan, medication sheets, and other documentation justifying medical necessity. 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:

Rationale for Requesting ECT:

Proposed physician and location for ECT:

Informed Request Y: N:

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: ________________________________

Revised Date: 02/05/14