ECT AUTHORIZATION REQUEST

Check One:
Outpatient ☐
Inpatient ☐

Check One:
Initial Series ☐
Continuation Series ☐

Requested Number of Sessions:

Requested Frequency:

Requested Start Date:

Requesting Hospital:

Client Medi-Cal Number:

Client Name:

Date of Birth:

Referring MD:

Administering MD:

Consulting MD (OP Only):

Administering MD Group Practice Name:

Contact Name TEL: FAX:

A. Primary ICD Diagnosis(es):

B. Indications for Initial ECT (Check Indications that are Present)

☐ Non-response to adequate medication trials for depression, mania, catatonia, or psychosis

☐ Rapid response needed due to medical risk in delaying ECT (e.g. dehydration)
If yes, what is the medical risk?

☐ Active danger to self/others

☐ Previous positive response to ECT

C. The indication for Continuation ECT is rapid relapse following an initial course of ECT and/or non-response to adequate post ECT medication. Please describe current clinical presentation that indicates need for Continuation ECT:

D. Attach Clinical Assessment Completed by the Requesting MD

E. Prior Episodes of Illness Treated with ECT:

Hospital:	# of ECT:	Date:	Response:	Time period to Relapse:
1.				
2				

F. Current Psychotropic Medication:

Medication:	Dose:	Start Date:	Response:	Current Blood Levels (Date Taken)
1.				
2.				
3.				
4.				

To be Completed by Optum

# of Sessions Authorized: Frequency: Begin Date: End Date:

Care Manager: Tel: Date:

Medical Director: Date: