OUTPATIENT ECT AUTHORIZATION REQUEST

Initial Series

Continuation Series

Requested Number of Sessions:_____

Requested Frequency: _____

Requested Start Date: _____

Client Medi-Cal Number:_____

Patient:_____ **Date of Birth:** _____/_____/_____

Requesting MD: _____ **Administering MD:**_____

Contact: _____ **Tele#:**_____ **FAX:**_____

A. Primary ICD 10 diagnosis(es): _____

B. Indications for Initial ECT (circle indications that are present)

1. Non-response to adequate medication trials for depression, mania, catatonia, or psychosis
2. Rapid response needed due to medical risk in delaying ECT (e.g. dehydration)
   a. If yes, what is the medical risk? _____
3. Active danger to self/others
4. 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:

Sessions Authorized:_____ Frequency:_____ Begin Date_____/_____/_____ End Date:_____/_____/

Care Manager:_____ Tele #_____ Date_____/_____/

Medical Director:_____ Date_____/_____/_____