# MACOMB COUNTY COMMUNITY MENTAL HEALTH
# ECT REQUEST FORM
**(PLEASE TYPE OR PRINT)**

Consumer Name _____ Adm Date _____ IP Facility Name _____
Guardian :_____OP Program Name _____
MCCMH Case #:_____ D.O.B. _____ Insurance: □ Indigent □ Caid □ Care/Caid □ Other _____

I. DSM V DIAGNOSIS

| ICD10 Code # |
|---|
| Diagnosis |

II. (A). LEVEL OF ECT SERVICE REQUESTED: □ Initial Request □ Continuation/Maintenance Request

___Acute Inpatient _____Outpatient

# of ECT's Year To Date _____
# of ECT's Previous Calendar Year _____

Number of ECT treatments being requested _____
Time frame ECT will be administered: From: _____ To: _____

Frequency of administration: _____

II. (B). RECOMMENDATION FOR ECT DOCUMENTED AND AGREEMENT FROM OUTPATIENT TREATING PSYCHIATRIST:

Outpatient Psychiatrist Name _____ Date Contacted: _____

III. (C) PLEASE IDENTIFY THE PLAN FOR FOLLOW UP AND/OR CONTINUED TREATMENT OF ECT PATIENTS AFTER DISCHARGE:(Make sure this meets MCCMH ECT Policy requirements)

_____
_____
_____

III. (A). DESCRIBE PATIENT'S CURRENT CLINICAL STATUS AND RATIONALE FOR PROPOSED INITIAL ECT (include target symptoms):

a. Legal Status: Voluntary _____ Involuntary _____ Court Order Date & Type:_____
b. Level of depression: Severe _____ Moderate _____ Mild _____ As Evidenced By _____

c. Neurovegatative Symptoms: Sleep: Appetite: Weight:
d. Level of Suicidality: (Check) Ideation Intent Plan Means Attempt: Recent Past
e. Psychotic Symptoms: (As Evidenced By) _____
f. Co-Morbid Substance Abuse: (Substance(s) used) _____
g. Significant Personality Disorder and or Intellectual Disability related Behaviors: _____

III. (B). PLEASE EXPLAIN RATIONALE FOR REQUEST OF ADDITIONAL ECT AND INDICATE HOW THE EFFECTIVENESS OF PREVIOUS ECT IS MEASURED (Continuation Request):

III. (C). PLEASE REPORT SYMPTOMS/PROBLEMS PRIOR TO ECT (pre-morbid state):

III. (D) PLEASE REPORT SYMPTOMS/PROBLEMS AFTER ECT (post-morbid state):

IV. LIST OF SIGNIFICANT MEDICAL PROBLEMS (Initial Request):

V. LIST OF ANY SUBSTANTIAL MEDICAL CONTRAINDICATIONS (Initial Request):

| | | | |
|---|---|---|---|
| 1. Space occupying cerebral lesions: | Present___ Absent__ | 5.Retinal detachment: | Present Absent__ |
| 2. High intra-cranial pressure: | Present Absent___ | 6. Pheochromocytoma: | Present Absent___ |
| 3. Recent myocardial infarction,with unstable cardiac function: | Present Absent__ | 7. High anesthesia risk: | Present Absent__ |
| 4. Recent intracerebral hemorrhage: | Present Absent___ | 8. Unstable aneurysm or malformation: | Present Absent___ |

VI. LIST OF ALL **CURRENT** MEDICATIONS (Initial and Continuation Requests):

| Drug Name | Strength | Dosing Schedule | Date Initiated |
|---|---|---|---|

VII. PAST TREATMENT HISTORY (Initial Request):

A. Psychiatric Hospitalizations (Initial Request):

| Date | Facility | Physician | ECT | Meds | Response |
|---|---|---|---|---|---|

B. **Medication History** (Initial Request):

| | Medication | Highest Dosage | From/To | Response |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |

VIII. PLEASE NOTE: The attending physician must enter adequate documentation in the medical record of the reasons for the procedure, that all reasonable treatment modalities have been carefully considered, and that the treatment is definitely indicated and is the most appropriate treatment available for this consumer at this time.

Form Completed By: _____

(PRINT NAME) (SIGNATURE) (Date)

## I have reviewed this request form and attest to the content and accuracy of information provided:

Attending Physician: _____

(PRINT NAME) (SIGNATURE) (Date)

IX. SECOND OPINION FOR ECT (Initial Request):

| | | | |
|---|---|---|---|
| 1. Have you personally examined this patient? | ____Yes | ____No | |
| 2. Does this patient have the capacity to give written informed consent for treatment? | ____Yes | ____No | |
| 3. Is written informed consent documented in patient's treatment records? | ____Yes | ____No | |
| 4. Are there any absolute medical or psychiatric contraindications for ECT? | ____Yes | ____No | |
| 5. (a) Is patient pregnant? If Yes, see (b) | ____Yes | ____No | ____N/A |
| (b) Is there an OB-GYN consult and clearance? | ____Yes | ____No | |
| 6. Has this patient been medically cleared? | ____Yes | ____No | |
| 7. I believe that Electroconvulsive treatment is the best treatment for this patient at this time and that other forms of treatment (especially psychiatric medications) would not be as effective. | ____Yes | ____No | |

Physician _____ Print Name _____ Date _____

(Second Opinion Signature)

Please return this completed request form to:

**MCCMH MANAGE CARE OPERATIONS**

**ATTN**: ACCOUNT CLERK / **CHIEF MEDICAL OFFICE**

Fax No.: (586) 948-0223

**cc: MCCMH Chief Medical Officer**