Cenpatico®
Improving Lives

ABSOLUTE TOTAL CARE
TOTAL | Healthy Connections PRIME

ELECTROCONVULSIVE THERAPY (ECT)

Please print clearly – incomplete or illegible forms will delay processing.

MEMBER INFORMATION

Member Name ______________________

Health Plan ______________________

DOB ______________________

SS # ______________________

Member ID # ______________________

Last Auth # ______________________

PROVIDER INFORMATION

Provider Name (print) ______________________

Hospital where ECT will be performed ______________________

Professional Credential: ☐ MD ☐ PhD ☐ Other __________

Physical Address ______________________

Phone ______________ Fax ______________

PREVIOUS BH/SUD TREATMENT

☐ None or ☐ OP ☐ MH ☐ SUD and/or ☐ IP ☐ MH ☐ SUD

List names and dates, include hospitalizations ______________________

____

Substance Use Disorder

☐ None ☐ By History and/or ☐ Current/Active

Substance(s) used, amount, frequency and last used ______________________

____

REQUESTED AUTHORIZATION FOR ECT

Please indicate type(s) of service provided by YOU and the frequency.

Total sessions requested ______________________

Type Bilateral __________ Unilateral __________

Frequency ______________________

Date first ECT __________ Date last ECT __________

Est. # of ECTs to complete treatment ______________________

Requested start date for authorization ______________________

CURRENT ICD DIAGNOSIS

Primary ______________________

R/O ______________ R/O ______________

Secondary ______________________

Tertiary ______________________

Additional ______________________

Additional ______________________

Danger to Self or Others (If yes, please explain)? ☐ Yes ☐ No

MSE Within Normal Limits (If no, please explain)? ☐ Yes ☐ No

LAST ECT INFO

Length ______________ Length of convulsion ______________

CURRENT RISK/LETHALITY

	1 NONE	2 LOW	3 MOD*	4 HIGH*	5 EXTREME*
Suicidal	☐	☐	☐	☐	☐
Homicidal	☐	☐	☐	☐	☐
Assault/ Violent Behavior	☐	☐	☐	☐	☐
Psychotic Symptoms	☐	☐	☐	☐	☐

*3, 4, or 5 please describe what safety precautions are in place

____

PCP COMMUNICATION

Has information been shared with the PCP regarding Behavioral Health Provider Contact Information, Date of Initial Visit, Presenting Problem, Diagnosis, and Medications Prescribed (if applicable)?

PCP communication completed via: ☐ Phone ☐ Fax ☐ Mail

Member Refused By ______________________

Coordination of care with other behavioral health providers? __________

Has informed consent been obtained from patient/guardian? __________

Date of most recent psychiatric evaluation ______________________

Date of most recent physical examination and indication of an anesthesiology consult was completed ______________________

SUBMIT TO
Utilization Management Department
12515-8 Research Blvd., Suite 400
Austin, Texas 78759
PHONE: 1.855.735.4398
FAX 1.877.725.7751

CURRENT PSYCHOTROPIC MEDICATIONS

Name	Dosage	Frequency

PSYCHIATRIC/MEDICAL HISTORY

Please indicate current acute symptoms member is experiencing: ______________________________

____

Please indicate any present or past history of medical problems including allergies, seizure history:______________________

____

REASON FOR ECT NEED

Please objectively define the reasons ECT is warranted including failed lower levels of care (including any medication trials) ____________

____

Please indicate what education about ECT has been provided to the family and which responsible party will transport patient to ECT appointments

____

____

ECT OUTCOME

Please indicate progress member has made to date with ECT treatment ______________________________

____

Standard Review:

Standard 14-day time frame will be applied.

____

Clinician Signature Date

Expedited Review:

By signing below, I certify that applying the standard 14-day time frame could seriously jeopardize the member's health, life or ability to regain maximum function.

____

Clinician Signature Date

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