magnolia health
Mississippi Children's Health Insurance Program

Cenpatico
Improving Lives

SUBMIT TO
Utilization Management Department
12515-8 Research Blvd., Suite 400
Austin, Texas 78759
PHONE 1.866.912.6285
FAX 1.866.694.3649

ELECTROCONVULSIVE THERAPY (ECT)

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

DEMOGRAPHICS

Patient Name _____

Health Plan _____

DOB _____

SSN _____

Patient ID _____

Last Auth #_____

PREVIOUS BH/SA TREATMENT

None or OP MH SA and/or IP MH SA

List names and dates, include hospitalizations _____

_____

Substance Abuse: None By History and/or Current/Active

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

_____

DSM IV Axis

AXIS I _____

AXIS II _____

AXIS III _____

AXIS IV _____

AXIS V _____

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

_____

_____

PROVIDER INFORMATION

Provider Name (print) _____

Location where ECT will be performed _____

Professional Credential: MD DO Other _____

Physical Address _____
(street address, city, state, zip code)

Phone _____ Fax _____

Medicaid/TPI/NPI #_____

Medicaid Tax ID #_____

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 _____

LAST ECT INFO

Length _____ Length of convulsion _____

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 on _____
via: Phone Fax Mail

Member Refused By _____
Signature/Title

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 _____

Have any questions? Call us at 1.866.912.6285
www.cenpatico.com

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 and member is pregnant _____

_____

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 _____

_____

ECT DISCONTINUATION

Please objectively define when ECTs will be discontinued – what changes will have occured _____

_____

Please indicate the plans for treatment and medication once ECT is completed _____

_____

Provider Name (please print)	Provider Signature	Date