Patient Demographics

Name: _____

Date of birth:_____ Sex:_____

Telephone:_____ Alt telephone:_____

O. K. to leave a voice message? No _____ Yes_____

Email address:_____

Mailing address:_____

_____

_____

Emergency Contact:_____ Number:_____

Insurance Provider:_____

Insurance Member ID:_____ Group#:_____

Phone Number for Provider Authorization:_____

How long have you know this patient?_____

Length of patient's current depressive episode?_____

Current Diagnosis/Diagnoses:_____

_____

Current/Target Symptoms:_____

_____

_____

Past History of ECT:

If YES, # of sessions:_____ Type: UL____ BF____ BT____

Dates:_____

Past response: Excellent____ Good____ Fair____ Poor____ Unknown_____

Past History of Ketamine? No_____ Yes_____ If yes, IV Ketamine_____ Nasal Ketamine

Past History of Substance Abuse? No_____ Yes _____

In remission_____ Active substance use_____

Please Describe:_____

_____

Current Medications:_____

_____

_____

_____

_____

_____

Reason for ECT referral_____

_____

Do we have permission to contact the patient? No_____ Yes_____

ADDITIONAL NOTES:

Clinical Impression:

Treating Psychiatrist Signature

Date