ValueOptions
TRICARE E.C.T. REQUEST FORM
P.O. Box 551188
Jacksonville, Florida 32255-2299
Telephone: (800) 700- 8646
Fax: (866) 811-4422

02/2006

I. GENERAL INFORMATION

PATIENT NAME: ____________________ SPONSOR ID: ____________________

PATIENT DOB: ____________________ DATE OF REQUEST: ____________________

PROVIDER: ____________________ PROVIDER PHONE: ____________________

FACILITY NAME: ____________________ FACILITY ID: ____________________

II. CLINICAL INFORMATION

DIAGNOSIS:

AXIS I: ____________________ AXIS II: ____________________ AXIS III: ____________________

CURRENT MEDICATIONS: (include all medications)

Medication	Dosage	Frequency	Start Date

CURRENT CLINICAL SIGNS AND SYMPTOMS (ENDOGENOUS):

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PREVIOUS ANTIDEPRESSANT (and augmentation) TRIALS:

Medication	Dosage	Date Initiated	Date D/C'd	Length of Tx at Therapeutic Dose

III. E.C.T. TREATMENT PLAN

NUMBER OF E.C.T. TREATMENTS REQUESTED: ____________________

☐ Unilateral ☐ OUTPATIENT
☐ Bilateral ☐ INPATIENT

IF INPATIENT E.C.T. IS REQUESTED, WHY IS OUTPATIENT E.C.T. CONTRAINDICATED FOR THIS PATIENT?

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IV. SUBMISSION INFORMATION

E.C.T REQUEST SUBMITTED BY: ☐ REQUESTING PROVIDER ☐ CASE MANAGER ON BEHALF OF PROVIDER

CASE MANAGER TO BE CONTACTED: ____________________ PHONE: ____________________