ECT PROVIDER REFERRAL FORM

PLEASE FAX TO 984.232.6836 OR SCAN TO HollyHillBrainStimulation@UHSInc.com

If Referral Requires Inpatient Hospitalization Please Contact 919.250.7000

Referral Date:_____

Referred By (Name & Agency):_____

Contact Number:_____Fax Number:_____

Patient Name:_____Patient DOB:_____Gender:_____

Patient Telephone:_____

Patient Address/Mailing:_____

Insurance Company, Policy Holder & Policy Number (can include copy of front/back insurance cared):

Does Patient Have a Guardian? (if yes, list name and contact info)_____

Is there a responsible adult who can provide transportation & wait with the patient? (yes or no)_____

Is Patient/Guardian Agreeing to ECT (Yes or no)?_____

Diagnosis (AXIS I-V. If MR give IQ Level):

Current Symptoms:

Psychotic Symptoms:

Current Medications:

Medication Trials (dates, medications, dosages, outcomes):