



ECT PROVIDER REFERRAL FORM

PLEASE FAX TO 919.231.5302 OR SCAN TO HollyHillBrainStimulation@UHSInc.com

Call 919.250.7000 with any questions or if this referral requires inpatient hospitalization.

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 card):

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):

Holly Hill South Campus Adult Hospital & ECT, 221 Michael J. Smith Lane, Raleigh, NC 27610

P. 919.900.5400