

Must be Performed and Completed by a Licensed Psychiatrist

Please complete this referral form before submitting via fax to our office. Incomplete forms not meeting criteria WILL be directed back to the source to complete before proceeding. Completed forms and all requested records can be faxed to:

**AMG Seton Behavioral Health
Fax #: 512-324-3379
ATTN: ECT Referrals**

PATIENT DEMOGRAPHIC INFORMATION			
Legal Name:		Date of Birth:	
Mailing Address:			
Primary Phone #:		Secondary Phone #:	
Email Address:			
PATIENT INSURANCE INFORMATION			
Primary Insurance:			
Member ID #:		Group #:	
Secondary Insurance:			
Member ID #:		Group #:	
Patient's Primary Care Physician:			
REFERRING PROVIDER INFORMATION			
Provider Name:		NPI #:	
Practice/Group Name:			
Practice Address:			
Provider Phone #:		Office Fax #:	

PATIENT HISTORY	
How long have you known this patient?	
Current Psychiatric Diagnosis (Include Codes):	
Current Medical Diagnosis (Include Codes):	
Length of Episode of Current Illness:	
History of Substance Use:	
History of Interventional treatments (TMS/ECT/Ketamine):	
Reason for Current ECT Referral:	

Please include the following when submitting the referral:

- A copy of the last progress note and initial psychiatric history and physical.
- Any EKG results performed in the last six months - include imaging results.
- A list of medications the patient is currently taking.
- Previous medication trials - dates, dosage, response
 - If you do not have a list templated, feel free to use the attached medication sheet.

The ECT physicians will be acting as consultants in the care of your patient. During the process of ECT, your patient will be instructed to contact you for issues related to medication management and psychiatric emergencies. You must also agree to follow up with the patient monthly during the course of their ECT treatment. If you have questions about medications, ECT side effects, or managements of your patient during the treatment series, please feel free to contact our team at 512-324-3380.

Please sign below to acknowledge that you have read and comply with the above statement.

Print Psychiatrist Name

Psychiatrist Signature

Date

