Electroconvulsive Therapy (ECT)
Phone: 719-355-1035
Fax: 719-638-4430
email: ECT@peakviewbh.com
Coordinator: Melissa Reynolds, RN

First Opinion for Electroconvulsive Therapy (ECT)

Date:

Patient name: **DOB:**

Patient phone number:

Psychiatric history: *Referral to be completed by MD, PA, or NP*

Psychiatric medication history (include dosages)(for Major Depressive Disorder, we especially need failed SSRI trials and failed adjunct medications such as Abilify):

Psychiatrist's initials:

Peak View
BEHAVIORAL HEALTH
Caring for Colorado

Electroconvulsive Therapy (ECT)
Phone: 719-355-1035
Fax: 719-638-4430
email: ECT@peakviewbh.
Coordinator: Melissa Reynolds, RN

First Opinion for Electroconvulsive Therapy (ECT)

Date:

Patient name: **DOB:**

Patient phone number:

Current prescribed medications (include dosages):

International Classification of Diseases (ICD)-10:

Primary:

Secondary:

Tertiary:

Why you feel ECT is needed:

Providers printed name: **Prescribers phone:**

Provider signature: _____ **Date:** _____