Referral for Electroconvulsive Therapy (ECT)

AT BOULDER COMMUNITY HEALTH

PHONE: 303-425-4299
FAX: 303-441-2202

First opinion referral for Electroconvulsive Therapy

Referring MD Name:

MD contact information:

Patient Name: DOB:

Patient contact information:

Mental health diagnosis: (check all that apply)

- ☐ Treatment Resistant Depression
- ☐ Major Depressive Disorder
- ☐ Bipolar D/O
- ☐ Catatonia
- ☐ Mania
- ☐ Schizophrenia / Schizoaffective (treatment resistant type)
- ☐ Other: (please specify)

History of treatment resistance: (check all that apply)

- ☐ Greater than two failed medication trials
- ☐ TMS fail
- ☐ Ketamine Fail

Current Medications: (include dosages)

Why is ECT reasonable at this time: (check all that apply)

- ☐ High acuity
- ☐ Treatment resistance
- ☐ Other: (please specify)

Referring MD's Signature: **Date:**

Please fax pertinent clinical notes and treatment history notes to 303-441-2202