HÔTEL-DIEU
ESTD GRACE 1888
HEALTHCARE

REFERRAL
ELECTROCONVULSIVE THERAPY (ECT)

Patient Information

Last Name: _____

First Name: _____ Middle Name: _____

Date of Birth: _____ (MM/DD/YYYY) Gender: ☐ Male ☐ Female

Health Card Number: _____ Version Code: |___|___|

Expiry Date: _____

Address: _____

City: _____ Province: _____ Country: _____

Postal Code: _____ Phone Number: _____

Contact Person

Last Name: _____ First Name: _____

Phone Number: _____

Referring Physician

Physician: _____ Ohip Billing Number: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Office Phone Number: _____ Fax Number: _____

Pharmacy Contact Information: _____

Physician to Physician Contact Information: _____

Admission Criteria: NOTE – INCOMPLETE FORMS NOT MEETING CRITERIA will be directed back to source

Information to be included with the Referral Form

- To be completed within 30 days prior to referral AND after start of ECT every 2 weeks:
  - MOCA, CLOX, Brief psychiatric rating scale (BPRS-18), Montgomery and Asberg (MADRS) Depression rating scale, Global Severity & Improvement scale ECT program

Fax the completed forms to HDGH ECT Intake Nurse: 519-257-5210

☐ The **referring physician must assume care of the patient** for the duration of the ECT treatment. The referring physician must **see the patient bi-weekly** during the treatment phase.

☐ ECT has been explained by the referring physician and patient/SDM is in agreement to proceed with ECT. Patient /SDM has been provided with the consent form.

I agree to abide by the above conditions.

_____ _____ (MM/DD/YYYY)

Psychiatrist Signature Date

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Allergies: ☐ latex ☐ malignant hyperthermia ☐ any other _____

Height: _____ cm Weight: _____kg

DSM Diagnosis:

Goal for ECT:

Target symptoms:

Method of tracking progress (how will you gage treatment response):

Presence of personality disorder/traits:

Medical Conditions:
☐ hypothyroidism
☐ anemia
☐ obstructive sleep apnea
☐ chronic pain/analgesia induced mood disorder
☐ substance induced mood disorder (including prescription psychotics/marihuana)
Other:

Current Medications including dosage, dates initiated and response (attach additional pages as necessary):

Current Herbals:

Cu

Current Over the Counter:

Past PSYCHIATRIC hospitalization: ☐ Yes ☐ No If yes, please include hospitalization/discharge records

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Has this patient received ECT treatment in the past? ☐ Yes ☐ No

Previous ECT Course Dates	Unilateral/Bilateral	# of Treatments	Comments

Previous treatment for this disorder (all **medications with duration, dosages and response, psychotherapy** etc.) (attach additional pages as necessary):

Is patient currently seeing a psychiatrist? If yes, who and how long?

Cautions/Notes to Psychiatrist administering ECT:

Psychiatrist Signature

Print Name

(MM/DD/YYYY)
Date