Santa Clara Valley Health & Hospital System
Behavioral Health Services
Electroconvulsive Therapy (ECT) Request Form

Date: ______________

Hospital Where ECT Will Be Provided: ____

Address: ____

Telephone No.: _________________________ Fax No.: _____________________________________

Contact Person: ____

Psychiatrist Requesting ECT: ____

Agency: ____

Work Address: ____

Telephone No.: ___________________________ Fax No.: ___________________________________

If requested by contract agency: ____

Printed Name / Signature of Contract Agency's Medical Director

Patient's Name: ____

Insurance ID Number (list if not MediCal/MediCare): _____________ DOB: ______________

- ☐ VMC Medical Record/Unicare Number: _______________________________________
- ☐ Identifying Information (Age, Marital Status, Living Situation, LPS legal status)
  ____
- ☐ DSM V Diagnoses: ____
- ☐ Can Patient Receive ECT on an Outpatient Basis? ☐ Yes ☐ No
  (if yes, list if any special needs including transportation)
  ____
- ☐ Brief Clinical History (Psychiatric Hospitalizations, medication history, Medications Major Medical Condition(s), Substance Use History if Applicable, and past response to ECT) ____

  Note: *Reason(s) for Planned Hospital Admission (Must meet Medi-Cal necessity criteria for inpatient stay – Consult with Dr. Tiffany Ho in advance)*

Approved By

Tiffany Ho, MD
Medical Director
Santa Clara County Behavioral Health Services

Date: __________