AdventHealth
Porter

1st Opinion For Electroconvulsive Therapy
PY108P

Patient Label

CONSW

Questions: 303-715-7765

Fax: 303-649-7147

1st Opinion For Electroconvulsive Therapy

Date: _____

Patient Name: _____DOB:_____

Patient Phone:_____Insurance:_____ID#_____

Psychiatric History and Bio-vegetative Symptoms:

_____
_____
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Psychiatric Medication History:

_____
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_____
_____

Psychiatrist Initials_____

Patient Label

CONSW

1st Opinion For Electroconvulsive Therapy

Patient Name: _____

Current Prescribed Medications:

_____
_____
_____
_____
_____
_____
_____

Axis I: _____
Axis II: _____
Axis III: _____
Axis IV: _____
Axis V: _____

Why you feel ECT is indicated:

_____
_____
_____
_____
_____
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_____
_____
_____
_____
_____
_____

Psychiatrist Signature:_____**Date:**_____

Psychiatrist Printed Name:_____

Psychiatrist Direct Phone Number: _____