REFERRAL FOR ECT TO THE GUERRA FISHER INSTITUTE LLC AT BOULDER COMMUNITY HEALTH

Questions: 303-415-8638 Fax: 303-440-2427

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: _____

_____

_____

_____

WHY IS ECT REASONABLE AT THIS TIME: (check all that apply)

- ☐ High Acuity
- ☐ Treatment Resistant
- ☐ Other (Please specify) _____

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

*Please fax pertinent clinical notes and treatment history notes to **303-440-2427**