Indiana University Health

ECT OUTPATIENT WORK-UP

PATIENT NAME: _____

These items must be ordered, completed and results returned to Methodist ECT department. A Methodist psychiatrist will review and agree to accept prior to patient starting ECT. Please fax results to 317.963.5131. Please check with the patient's insurance before ordering these tests to insure that IU Health is in-network for ECT.

_____ 1. FULL PSYCHIATRIC EVALUATION: Most recent one completed by the referring psychiatrist. (Also include recent progress notes.)

_____ 2. COMPLETE HISTORY AND PHYSICAL: Recent (Also any recent progress notes.)

_____ 3. EKG: Within the past 30 days.

_____ 4. CXR: (Optional) Required if history of lung disease or smoker.

_____ 5. HEAD CT OR MRI: Without contrast: Within past 6 months.

_____ 6. SPINAL FILMS: (Optional) - Required if history of osteoporosis, spinal problems or back surgery.

_____ 7. COMPREHENSIVE METABOLIC PANEL: Within past 30 days.

_____ 8. CBC w/Diff: Within past 30 days.

_____ 9. TSH: Within past 30 days.

_____ 10. PREGNANCY TEST: If patient within childbearing age and not surgically sterilized.

_____ 11. INSURANCE INFORMATION: Copy of insurance card (front and back.)

_____ 12. FACE SHEET: Demographic information.

_____ 13. CURRENT MEDICATION LIST: Including allergies.

Maintenance ECT Schedule

Every week x 4

1. _____
2. _____
3. _____
4. _____

Every other week x 4

1. _____
2. _____
3. _____
4. _____

Monthly x 2

1._____
2._____

Mini-Maintenance ECT Schedule

Every week x 2

1._____

2._____

Every other week x 2

1._____

2._____

Monthly x 2

1._____