Lindner Center of HOPE | UC Health

FAX TO: 513-536-0779

REFERRAL FORM FOR ECT / TMS

DEMOGRAPHICS

Client's Legal Name: _____ D.O.B.: _____

Home Phone: _____ Cell: _____

Address: _____

_____

Client's Insurance: Type: _____ Card # _____

Psychiatrist Name: _____

Phone: _____ Fax: _____

Diagnosis & AXIS I-V *Please attach client's 3 most recent progress notes*

I. _____ II. _____ III. _____

IV. _____ V. _____

Service referral is for: ECT / TMS REASON FOR REFERRAL FOR CONSULTATION

_____

_____

_____

_____

_____

RELEVANT MEDICAL HISTORY

Please circle all that apply:

Endocrine Neurological Respiratory Cardiac Metal in body Other issues N/A

If yes please specify:

_____

_____

_____

Please attach a list of patient's current and past psychiatric medications. A medication sheet is attached for your convenience if needed.

Psychiatrist's Signature: _____ Date: _____ Time: _____

MEDICATION HISTORY

CURRENT MEDICATIONS (Psychiatric and Non-Psychiatric)	Medication Trial Duration (Start Date)	Dose / Frequency	Response & Adverse Effects

PAST Psychiatric MEDICATIONS	Medication Trial Duration (Start Date and End Date)	Dose / Frequency	Response & Adverse Effects

Please attach client's 3 most recent progress notes