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 *Also 3 progress notes - most current

I. _____ II. _____ III. _____

IV. _____ V. _____

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

_____

_____

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## 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) attach additional information if needed. | Dose / Frequency | Response & Adverse Effects |
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| PAST Psychiatric MEDICATIONS | Dose / Frequency | Response & Adverse Effects |
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