



**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 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: \_\_\_\_\_

