

## Consultation Request/Referral Form for ECT Clinic

Please complete this form and email or fax with any questions to 541-706-7706, Attn. Intake Specialist, OPBH.

Patient name: \_\_\_\_\_

Patient DOB: \_\_\_\_\_

Patient phone number: \_\_\_\_\_

Patient email address: \_\_\_\_\_

Medical record number: \_\_\_\_\_

Referring psychiatrist/provider: \_\_\_\_\_

Other providers involved in longitudinal care: \_\_\_\_\_

Psychiatric diagnoses: \_\_\_\_\_

Has the patient ever experienced psychotic symptoms? Y/N. If Y, please provide more information:

Current medications and doses (including all supplements):

Past medication trials (please add doses and duration, if known):

## Psychiatric History

Age of depression onset: \_\_\_\_\_

Length of current illness: \_\_\_\_\_

Hospitalizations: \_\_\_\_\_

Suicide history: \_\_\_\_\_

Self-harm: \_\_\_\_\_

Medical History Allergies: \_\_\_\_\_

Medical: \_\_\_\_\_

Surgical: \_\_\_\_\_

Anesthetic history: \_\_\_\_\_

Imaging studies: \_\_\_\_\_

Substance history alcohol: \_\_\_\_\_

Drugs: \_\_\_\_\_

Caffeine: \_\_\_\_\_

Tobacco: \_\_\_\_\_

Rehab/Detox: \_\_\_\_\_

## Social History

Birth: \_\_\_\_\_

Education: \_\_\_\_\_

Marital status: \_\_\_\_\_

Children: \_\_\_\_\_

Living situation: \_\_\_\_\_



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Employment: \_\_\_\_\_

Family history mood disorders: \_\_\_\_\_

Alcoholism: \_\_\_\_\_

Suicides: \_\_\_\_\_

Clinician Name: \_\_\_\_\_

Clinician signature:

Date:

**Clinician contact information**

Office name: \_\_\_\_\_

Phone number: \_\_\_\_\_

Fax #: \_\_\_\_\_

Email address: \_\_\_\_\_