St. Charles HEALTH SYSTEM

2500 NE Neff Road
Bend, Oregon 97701
541.382.4321
www.stcharleshealthcare.org

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):

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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: _____