



AETNA BETTER HEALTH® OF KENTUCKY
Initial & Concurrent ECT/TMS Prospective Request

Please complete and fax this review form to 855-301-1564.

Optional Case Reference # _____

Today's date:	ECT Location	<input type="checkbox"/> IP	<input type="checkbox"/> OP	<input type="checkbox"/> TMS
Facility name:	MD name:			
Facility NPI #:	MD NPI #:			
Facility fax #:	MD direct phone #:	, Ext		
Patient name:	MD Fax #:			
Patient ID #:	Facility/MD services	Include:	Exclude:	
Date ECT/TMS to begin:	DOB	Age	Sex	<input type="checkbox"/> M <input type="checkbox"/> F

Diagnosis (Please report complete psychiatric diagnosis below)

Medications (Please report psychotropic medication below and include PRNs)

Primary ICD 10 diagnosis:	Medication (routine)	Amount	Freq.	Compliance
ICD 10 Diagnosis:				<input type="checkbox"/> Y <input type="checkbox"/> N
ICD 10 Diagnosis:				<input type="checkbox"/> Y <input type="checkbox"/> N
Comorbid Medical ICD 10 Dx:				<input type="checkbox"/> Y <input type="checkbox"/> N
Comorbid Medical ICD 10 Dx:				<input type="checkbox"/> Y <input type="checkbox"/> N
Psychosocial factors:	Medication (prn)	Amount	Freq.	Compliance
Attending psychotherapy? <input type="checkbox"/> Y <input type="checkbox"/> N Frequency:				<input type="checkbox"/> Y <input type="checkbox"/> N

History: All of the following must be faxed along with this form

<input type="checkbox"/>	Recent COMPREHENSIVE Psychiatric Evaluation
<input type="checkbox"/>	History of Psychiatric Treatment to date (include all levels of care); <ul style="list-style-type: none"> • Include onset, course, and severity of illness • Response to Treatment • Describe Patients overall Treatment Compliance • Include Prior ECT Treatments and Response to Treatment(s) (Positive or Negative): <ul style="list-style-type: none"> - Most recent stimulus, electrode / coil placement, and description of seizure response; - Response to Treatment (cognitive, affective, and behavioral progress); - Complications or Adverse effects
<input type="checkbox"/>	History of Substance Abuse Treatment to date (include all levels of care), & Date of last use:
<input type="checkbox"/>	Psychotropic Medication History (Include: Medications, Dates, Response, Adverse Affects)
<input type="checkbox"/>	Medical History and Medical Clearance (describe):
List the Rating Scale(s) that were used to monitor progress?	
Baseline Score/Date:	Current Score/Date:

Areas of concern: (please check all that apply)

<input type="checkbox"/>	Presence of a cognitive disorder
<input type="checkbox"/>	Lack of housing or family/social supports for transition from IP ECT to OP ECT
<input type="checkbox"/>	Presence of a significant personality disorder

Proposed treatment plan:

TX Request for <input type="checkbox"/> Initial (Index) <input type="checkbox"/> Concurrent	ECT Code/# of visits requested: <input type="checkbox"/> 0901 : # <input type="checkbox"/> 90870 : #	Frequency/time span: Per week/month Dates: From To #Visits Completed to date
Lead placement: <input type="checkbox"/> Unilateral <input type="checkbox"/> Bi-frontal <input type="checkbox"/> Bi-temporal		
<input type="checkbox"/> Information consent obtained		

By signing below I attest the reported information to be true and accurate to the best of my knowledge and is congruent with the medical record.

Request form completed by and credentials:	Date:
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