Centennial Peaks HOSPITAL

Referral Letter for Outpatient Providers
1st Opinion for ECT

Date: _____

Patient Name: _____

DOB: _____ Patient Phone Number: _____

Insurance Carrier: _____

Mental Health Diagnosis: _____

Family Mental Health History: _____

_____

Brief Mental Status Exam: _____

_____

Medication Trials: _____

_____

Current Medications: _____

_____

Medical History: _____

_____

Explanation for Referral for ECT: _____

_____

_____

Does patient have support system/monitoring post Anesthesia? ☐ YES ☐ NO

Provider Signature: _____ Date: _____ Time: _____

Printed Name: _____

If you have a copy of recent H&P, Insurance card and/or current labs including CBC, CMP, TSH, and EKG, please include and fax to 303-395-0470