OREGON HEALTH & SCIENCE UNIVERSITY
School of Medicine
Department of Psychiatry
Electroconvulsive Therapy Clinic

Mail code: OP02
3181 S.W. Sam Jackson Park Rd
Portland, OR 97239 -3098

tel: 503-494-6183
referral fax: 503-346-6854
Clinic fax: 503-494-6170

Electroconvulsive Therapy (ECT) Consult Form

We require that patients are engaged in mental health care with a Psychiatrist or a Psychiatric Mental Health Nurse Practitioner prior to ECT consultation, and that the provider agree to follow them during the course of ECT and afterward.

Please have treating mental health provider complete ALL sections and fax with chart notes to 503-346-6854.

Referral history (Please include any history of suicidality, psychosis, catatonia, recent psychiatric admissions):

2. Diagnosis with ICD10:

3. Prior Medication Trials with doses and duration of treatment if available:

4. Past Medical History:

5. Psychiatrist or Psychiatric Mental Health Nurse Practitioner who will continue to follow them during and after ECT:
   Name:
   Specialty:
   Phone:
   Fax:

6. Patient Demographics and Insurance:

   Patient Name:
   Date of Birth:
   Address:
   City, State, Zip Code:
   Home Phone: Work: Cell:

   Insurance Information:
   Company: Policy Holder Name:
   Subscriber ID #: Group #:
   Insurance Phone #: