

Referral Date

Referring MD

Patient Name

ECT Supervisor (clinic use only)

(A) Patient Information (may use addressograph)

| (1) Gender | (2) Date of birth | (3) Course | (4) Referral source |
|--|-------------------|--|--|
| <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> PHN | | <input type="checkbox"/> Acute <input type="checkbox"/> Maintenance | <input type="checkbox"/> Inpatient (go to number 5) <input type="checkbox"/> Outpatient (go to number 6 or 7) |

(5) For inpatient course from:

| | | | |
|---|--|---|---|
| <input type="checkbox"/> Vancouver General Hospital | <input type="checkbox"/> Tertiary Older Adult - Willow | <input type="checkbox"/> Tertiary Adult - Willow | <input type="checkbox"/> Other (specify): |
| <input type="checkbox"/> UBC Hospital | <input type="checkbox"/> Tertiary Older Adult - Parkview | <input type="checkbox"/> Forensic Psychiatric Institute | |

(6) For outpatient treatments from inpatient admission at:

| | | | |
|---|--|---|---|
| <input type="checkbox"/> Vancouver General Hospital | <input type="checkbox"/> Tertiary Older Adult - Willow | <input type="checkbox"/> Tertiary Adult - Willow | <input type="checkbox"/> Other (specify): |
| <input type="checkbox"/> UBC Hospital | <input type="checkbox"/> Tertiary Older Adult - Parkview | <input type="checkbox"/> Forensic Psychiatric Institute | |

(7) For outpatient treatments from community:

| | |
|--|---|
| <input type="checkbox"/> Mental Health Team (specify): | <input type="checkbox"/> Family Physician |
| <input type="checkbox"/> Case Manager (specify): | <input type="checkbox"/> Phone number: |
| <input type="checkbox"/> Home address: | |

(B) Clinical Information

(8) Diagnosis (choose one)

| | | |
|---|---|---|
| <input type="checkbox"/> Bipolar D/O | <input type="checkbox"/> Psychotic D/O | <input type="checkbox"/> Other (specify): |
| <input type="checkbox"/> Major Depressive D/O | <input type="checkbox"/> Depressive D/O NOS | |

(9) Target symptom (choose all that apply)

| | | | |
|---|--------------------------------------|---|------------------------------------|
| <input type="checkbox"/> Suicide | <input type="checkbox"/> Psychosis | <input type="checkbox"/> Mania | <input type="checkbox"/> Catatonia |
| <input type="checkbox"/> Depressed Mood | <input type="checkbox"/> Poor intake | <input type="checkbox"/> Other (specify): | |

(10) Previous ECT response

| | | |
|------------------------------|--|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> Voluntary-SDM | <input type="checkbox"/> Involuntary (MHA) |
| <input type="checkbox"/> No | <input type="checkbox"/> Voluntary-Patient | <input type="checkbox"/> Other (specify): |

(11) Consent (choose one)

(12) ASA if known (0-4):

(13) Investigations (complete within 10 days of starting ECT for inpatients; within 30 days for outpatients - we can arrange):

| |
|--|
| <input type="checkbox"/> Current Medication List (required) |
| <input type="checkbox"/> EKG (required) |
| <input type="checkbox"/> Anesthesia Consultation, including dental status (required) |
| <input type="checkbox"/> Bloodwork: CBC and Differential, Electrolytes, BUN, Creatinine, ALT, AST, GGT, TSH (required) |
| <input type="checkbox"/> Optional Based on Clinical Situation: Chest X-Ray, CT Scan Head |

(C) Safety Factors

(14) Medical issues (Choose all that apply)

| | | | |
|--|---|-------------------------------|---|
| <input type="checkbox"/> Diabetic | <input type="checkbox"/> Fall Risk | <input type="checkbox"/> MSRA | <input type="checkbox"/> Other Infection (specify): |
| <input type="checkbox"/> Moderate to Severe Dementia | <input type="checkbox"/> Heavy Transfer | <input type="checkbox"/> VRE | |

(15) Behavioural dysregulation

| | |
|--|--|
| <input type="checkbox"/> Verbal agitation/aggression | <input type="checkbox"/> Physical agitation/aggression |
|--|--|

PLEASE FAX COMPLETED FORM TO 604.675.2464 (TELEPHONE 604.675.2449)
PLEASE NOTE THAT OUTPATIENTS MUST BE ABLE TO MAINTAIN NPO STATUS PRIOR TO TREATMENTS
AND MUST HAVE POST-ECT RECOVERY SUPERVISION BY A RESPONSIBLE ADULT FOR 24 HOURS.