SAULT AREA HOSPITAL
HÔPITAL DE SAULT-SAINTE-MARIE

iCare

DEMOGRAPHIC LABEL

Outpatient Mental Health Services

Electroconvulsive Therapy (ECT) Referral Form

Diagnostic & Statistical Manual of Mental Disorders (DSM) Diagnosis: _____

Target Symptoms for ECT: (specify if maintenance course)

_____

_____

Reason for Prescribing:

_____

_____

Type of ECT considered: ☐ Unilateral ☐ Bilateral ☐ Other: _____

MILD/CHRONIC	MODERATE	SEVERE	LIFE-THREATENING
☐ Mildly-depressed mood	☐ Moderately- depressed mood	☐ Severely-depressed mood	☐ Suicidal w/plan and intent
☐ Managing at home	☐ Difficulty managing at home	☐ Expresses suicidal ideation	☐ Not eating or drinking
☐ Symptoms not getting worse	☐ Symptoms are worse	☐ Psychotic	☐ Catatonic
☐ Resources/Supports available	☐ Chronic suicidal ideation	☐ Manic	☐ Delirium
		☐ Pregnancy/post-partum	☐ Post-partum psychosis
		☐ Medical reasons	
		☐ Admitted to hospital	

Present Medical Diagnosis/Pertinent Medical History:

_____

_____

_____

Mental Status Exam:

_____

_____

_____

Is Patient Capable of Consent? ☐ Yes ☐ No ☐ Substitute Decision-Maker

☐ ECT nurse to provide education

Provider Signature: _____ Date: _____