McLean HOSPITAL
HARVARD MEDICAL SCHOOL AFFILIATE

Electroconvulsive Therapy (ECT) Clinician Referral Form

Patient Name: _____ **Date:** _____

Patient DOB: _____ **Patient Phone:** _____

Address: _____

Insurance: _____

Diagnosis and Reason for Referral:

_____

_____

_____

Medical Conditions:

_____

_____

_____

Current Medications and Doses:

_____

_____

_____

Past Medication Trials: Please provide dosages, duration and efficacy of drug trials.

_____

_____

_____

_____

Physician Name: _____

Address: _____

Phone: _____ **Fax:** _____ **Email:** _____

Please note: If you feel your patient is too acutely ill to wait for an appointment, you can refer him/her for inpatient hospitalization at 800.333.0338. For a list of other outpatient programs or with any questions regarding ECT, please call 617.855.2356.

Please fax the completed form to 617.855.3810 or mail to McLean Hospital, Attn: ECT Department, 115 Mill Street, Belmont, MA 02478.