Electroconvulsive Therapy (ECT) Referral Form

Please fax the completed form, along with medical records, to 919-668-2595. If you have questions about your referral or if this is an urgent request, please call Duke Behavioral Health Center North Durham at 919-684-0100.

Referring Physician Information

Referring Physician: ______________________ Date: ______________________
Practice/Group Name: ______________________
Address: ______________________
City/State: ______________________ Zip Code: ______________________
Office Phone: ______________________ Office Fax: ______________________
Referral Coordinator: ______________________ Phone Ext: ______________________

Patient Information

Patient Name: ______________________ Sex: __________
Social Security #: ______________________ Duke MRN: __________ Date of Birth: __________
Address: ______________________
City/State: ______________________ Zip Code: ______________________
Home Phone: ______________________ Patient E-mail: ______________________
Work Phone: ______________________ Cell Phone: ______________________
Parent or Guardian Name if Minor: ______________________

Insurance Information

Attach copy of insurance cards (front & back) with complete insurance information OR complete the following:

Insurance Plan: ______________________ Ins. Co. Phone #: ______________________
Ins. Co. Address (only if commercial plan): ______________________ State: __________ Zip Code: __________
Subscriber ID: ______________________ Member ID (if different from Subscriber ID): __________
Subscriber Name: ______________________ Subscriber DOB: __________ Group #: __________
Subscriber Relationship to Patient: ______________________ Guarantor (If different from Subscriber): __________
Guarantor DOB: ______________________ Guarantor Phone Number: ______________________
Is this a plan with referral restrictions? ☐ YES ☐ NO Referral/Authorization #: ______________________
Is this patient with Medicaid? ☐ NC Medicaid ☐ Non-NC Medicaid ☐ NO Carolina Access # __________
Is Workers' Compensation or litigation involved? ☐ YES ☐ NO

Appointment Request

Reason for Appointment (please document prior treatment failures or attach medical records): ______________________

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Previous ECT or other brain stimulation (document here or attach records): ______________________

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For Office Use Only

Appointment Date and Time: ______________________
Department/Physician: ______________________
Location: ______________________
Patient notified? ☐ YES ☐ NO Spoke with patient: __________ Left message: __________ Via letter: __________
Referring office notified ? ☐ YES ☐ NO Left message: __________ Via Medlink: __________
Notes: ______________________

Thank you for referring your patient to Duke Health.