METROWEST MEDICAL CENTER
Framingham Union Hospital • Leonard Morse Hospital

Electroconvulsive Therapy (ECT) Referral Form

Patient Name: _____ DOB:___ /___ /____

Address: _____ City: _____ Zip Code: _____

Phone: _____ Email: _____

Primary Insurance: _____

Secondary Insurance: _____

Diagnosis & Reason for Referral:

_____

_____

Medical Conditions:

_____

_____

_____

Current Medications & Doses:

_____

_____

_____

_____

Past Medication Trials (Medication, dosage, duration, efficacy):

_____

_____

_____

_____

ECT Treatment History (Duration, Efficacy):

_____

_____

_____

Physician Name: _____

Address: _____ City: _____ Zip Code: _____

Phone: _____ Fax: _____ Email: _____

Please fax completed form to 508-650-7128 or 508-650-7061. For inpatient referrals, please include patient demographics, medication orders, labs, H&P and nursing notes.