ECT Consultation Questionnaire

Name	DOB	MRN

Registration Information (Insurance, Phone, Address)

Current Patient Custody

☐ Parent(s)	☐ Legal Guardian	☐ DCF
☐ Foster Care	☐ Self	☐ Other:

Reason for ECT Consultation / Present Symptoms

Present Psychiatric Diagnoses

Substance Use (current or past 6 months)

Eating Disorder Concern (current or past 6 months)

Present Psychiatric Medications (include doses)

Psychiatric Medication History (dose and duration)

Referring Psychiatrist Name and Contact Information
