BUTLER
HOSPITAL

ECT Program - Client Referral

Client:	DOB:	SS#:
Preferred Phone #:	Alternate Phone #:	
Address:	City:	
State:	Zip Code:	
Primary Insurance:	Subscriber:	Pol. #:
Secondary Insurance:	Subscriber:	Pol. #:

Client Referral Requires:

- ☐ Letter of Referral from outpatient provider
- ☐ Three most recent progress notes or reports
- ☐ Current medication profile
- ☐ Current insurance information

Emergency Contact: _____ _____ _____	_____ Referring Physician (Please Print) _____ Date

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