Medical Staff Services

UPSTATE UNIVERSITY HOSPITAL

ANNUAL ECT (ELECTROSHOCK THERAPY) CASE REVIEW FORM

Provider being reviewed: ____ **Department:** _Psychiatry

Timeframe: ____________________________________ **Reviewer:** ____

ADMIT DATE	ACCOUNT / MR#	PROCEDURE NOTE REVIEW	COMMENTS
		Documentation of rationale for ECT treatment present? Y ___ N ___ Documentation of medical clearance prior to ECT treatment present? Y ___ N ___ Evidence that therapeutic outcome has been assessed? Y ___ N ___ Evidence that adverse cognitive effects have been assessed? Y ___ N ___	
		Documentation of rationale for ECT treatment present? Y ___ N ___ Documentation of medical clearance prior to ECT treatment present? Y ___ N ___ Evidence that therapeutic outcome has been assessed? Y ___ N ___ Evidence that adverse cognitive effects have been assessed? Y ___ N ___	
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Please fax (315-464-8524) or e-mail (medstaff@upstate.edu) to Medical Staff Services when complete.

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