BUTLER HOSPITAL
A MEMBER OF CARE NEW ENGLAND

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

345 Blackstone Boulevard | Riverview Building | Providence | RI | 02906 | Phone: (401) 455-6426 | Fax: (401) 680-4168