ECT Referral Form

Patient Name: _____

Date of Birth: _____

Address: _____

City/State/Zip _____

Phone: _____

Preferred Facility for Treatment:

☐ Glendale (6015 W Peoria Ave, Glendale, AZ 85302)

☐ Tempe (6350 S Maple Ave, Tempe, AZ 85283)

Insurance Provider: _____

Member ID: _____

Group Number: _____

Issue of concern:

Referral Source:

Please complete this form and email to Patient.Services@AuroraBehavioral.com. Our ECT Coordinator will reach out the next business day to schedule a consultation.