VAN DIEST MEDICAL CENTER

An Affiliate of MERCYONE.

Ketamine Clinic Referral Checklist

☐ Completed ketamine clinic referral form

☐ Ensure referral form is signed by an MD or PMHNP

☐ Last 2-3 psychiatric visit notes

- Ensure there is documentation that the patient has failed 3 or more oral antidepressant trials

- Ensure that there is documentation of at least one augmentation trial attempt

☐ Current medication list

☐ Ensure that patient is free from any active substance abuse (to include marijuana and alcohol)

☐ Include any pertinent notes related to the patient's condition (patient needs extra time, requires handicap assistance, etc)

Fax all completed ketamine clinic referrals to:

Shyla Smith-West

Van Diest Medical Center Specialty Clinic

Fax: 515-832-9430 Phone: 515-832-7746

Van Diest Medical Center
Ketamine Treatment Clinic
2350 Hospital Drive
Webster City, IA, 50595
Phone: 515-832-7746 Fax: 515-832-9430

Ketamine Clinic Referral Form

PATIENT AND CLINIC INFORMATION

Patient Name:_____ Date of Birth:_____

Age:_____ Allergies:_____

Primary Mental Health Provider (Circle One):_____

Primary Care/ Mental Health Provider Address: _____

_____

_____

Phone Number: _____ Fax Number:_____

Patient's Phone Number:_____

KETAMINE THERAPY OPTIONS

Requested Therapy (check all that apply): ☐ Ketamine Therapy for Treatment Refractory Depression (Intravenous Route) 0.5-1.0 mg/kg IV over 40 minutes

☐ Spravato™ (esketamine) Therapy for Treatment Refractory Depression (intranasal route) 56 mg and 84 mg doses (Ages > 18)

Depression Diagnosis (with ICD-10 Code)*:

☐ **Major depressive disorder, single episode, mild (F32.0)** ☐ **Major Depressive disorder, single episode, moderate (F32.1)**

☐ **Major depressive disorder, single episode, without psychotic features (F32.2)**

☐ **Major depressive disorder, single episode, unspecified (F 32.9)**

☐ **Major depressive disorder, recurrent, mild (F33.1)** ☐ **Major depressive disorder, recurrent, moderate (F33.1)**

☐ **Major depressive disorder, recurrent, severe without psychotic features (F33.2)**

☐ **Major depressive disorder recurrent, unspecified (F33.9)**

☐ **Other diagnosis**:_____

Ketamine therapy is NOT indicated for a primary diagnosis of dysthymia, bipolar disorder (without major depressive disorder), schizophrenia, schizoaffective disorder, or personality disorders (schizotypal, borderline, obsessive-compulsive, etc.)

Patient Name:_____

Van Diest Medical Center
Ketamine Treatment Clinic
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Webster City, IA, 50595
Phone: 515-832-7746 Fax: 515-832-9430

PATIENT DEPRESSION HISTORY:

Duration of Symptoms:_____ Is the depression treatment refractory? YES NO

Current Symptoms:_____

_____

Suicidal Ideations Present? YES NO

Has the patient attempted suicide in the past? YES NO

Is the patient currently taking anti-depressants? YES NO

Does the patient currently use illicit drugs, and/or have a history of alcohol abuse? **YES*** NO
*(*Patients with current illicit drug use or alcohol abuse are not candidates for ketamine therapy)*

Current antidepressant medications, dosages, and start date of therapy:

1._____

2._____

3._____

4._____

5._____

Have the medications been effective in reducing depression symptoms? YES NO

If the patient is not currently taking any anti-depressants, have they taken them before? YES NO

Please list previous medications, dates of usage, start/stop dates which were ineffective for treatment of depression:

1._____

2._____

3._____

4._____

Other notes about the patient's history of depression: _____

_____

_____

_____

Based on my patient's current diagnosis of treatment-refractory major depressive disorder, I request that my patient be evaluated and, if appropriate, receive the selected ketamine therapy option indicated on page one.

Referring Provider Name and Title: _____

Signature: _____ Date and Time: _____