1118 Woodland Drive, Elizabethtown, KY 42701 *Phone (270) 982-0825

Please Fax Referrals to 1-833-471-5852

PATIENT AND CLINIC INFORMATION

Patient Name: ______________________________ Date of Birth: ___________ Age:____

Allergies: ____

Primary Care Provider/ Mental Health Provider (Circle One): Primary Care/ Mental Health

Provider Address: ____

____

Phone Number: ____________________ Fax Number: ______________________

Provider's Clinical Email: ____

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 40-60 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 (F33.0)
- ☐ 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 ____

1118 Woodland Drive, Elizabethtown, KY 42701 *Phone (270) 982-0825

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

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

1.

2.

3.

4.

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:*** __________________