CORRIDOR KETAMINE
STOP STRUGGLING. START LIVING.

Phone: 319-337-8329
Fax: 319-337-8692
www.corridorketamine.com
Referral Form

PATIENT AND CLINIC INFORMATION

Patient Name:_____Date of Birth:_____ Age: _____

Patient's Phone #: _____ Patient's Email : _____

Allergies:_____

Primary Care Provider/ Mental Health Provider (Circle One)

Primary Care/ Mental Health Provider Address:

_____

_____

Phone Number:_____Fax Number:_____

Mental Health Provider's Clinical Email Address: _____

(If you'd like updates on your patient's progress – please provide an email address!)

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 only)

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 (F32.9)

□ 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: _____

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PATIENT DEPRESSION HISTORY

Duration of Symptoms:_____Is the depression treatment refractory? **YES** **NO**

Current Symptoms:_____

_____

_____

_____

History of or Current Substance Abuse Disorder? **YES** **NO**

If yes, list disorder and any other pertinent details (e.g. treatment course/plan, current management, length of remission, etc.): _____

Suicidal Ideations Present? **YES** **NO**

Has the patient attempted suicide in the past? **YES** **NO**

Is the patient currently taking anti-depressants? **YES** **NO**

History of psychosis? (If yes, provide details): **YES** **NO**_____

(Note: Per FDA guidelines, patient *must* currently be taking an antidepressant to receive Spravato treatment)

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 pt. is NOT currently taking any anti-depressants, have they taken them before? **YES** **NO**

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

1._____ 4._____

2._____ 5._____

3._____ 6._____

Does the patient have a history of any contraindications to ketamine/esketamine therapy, to include **blood vessel (aneurysmal vascular) disease** (including in the brain, chest, abdominal aorta, arms and legs), an abnormal connection between their veins and arteries (**arteriovenous malformation, or "AVM"**), a history of **bleeding in the brain**, or an **allergic reaction** or ketamine/esketamine? **YES** **NO**

If so, please list: _____

Any 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 & Time: _____

HOW WOULD YOU PREFER TO RECEIVE PATIENT UPDATES (CIRCLE ONE): FAX EMAIL

*****REMINDER***** If you would like to receive updates on your patient via email, please provide a valid email address on the first page of this referral form!