CORRIDOR KETAMINE
STOP STRUGGLING. START LIVING.

1900 James St STE1 Coralville, IA 52241
1740 Lininger Ln, North Liberty, IA 52317
5107 Utica Ridge Rd, Davenport, IA 52807
Phone: 319-337-8329
Fax: 319-337-8692

PATIENT AND CLINIC INFORMATION
Referral Form

Patient Name:_____Date of Birth:_____ Age: _____

Patient's Phone Number: _____Patient's Email: _____

Referring Provider **(Check One):** ☐Primary Care Provider ☐Mental Health Provider

Referring Provider Practice 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):

☐ IV Ketamine Therapy for Treatment Refractory Depression

- (Intravenous) 0.5-1.0 mg/kg IV over 40 minutes

☐ Spravato™ (esketamine) Therapy for Treatment Refractory Depression

- (Intranasal) 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

****Along with this completed referral, please fax us copies of the last **three** clinic notes and complete medication records, including past and current medications. ****

Length of current depressive episode:_____

_____

Is the depression treatment refractory? ☐ **YES** ☐ **NO**

Current Symptoms: _____

_____

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

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

_____

Is the patient currently experiencing suicidal ideation with intent as defined by having **BOTH:**

1.) Thoughts, even momentarily, of self-harm with at least some intent or awareness that they may die as a result, or the patient thinks about suicide, **AND** 2.) The patient intends to act on thoughts of killing themselves. ☐ **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**

Current antidepressant medications and augmenting agents, dosages, and start of therapy:

1. _____
2. _____
3. _____
4. _____

Any Known Allergies: _____

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 provide a list of **previously used antidepressant medications and augmentation therapies, including dates of use/start and stop dates**, that were ineffective in treating 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.

(*We do not accept verbal orders. Form must be signed by the referring provider.)*

Referring Provider Name and Title: _____

Signature: _____

Date: _____

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!