

PATIENTS WILL BE EVALUATED FOR BOTH PROGRAMS

IV Ketamine

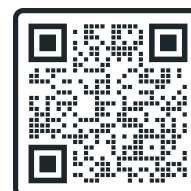
1100 Dundas Street W. Unit # 7/8
Mississauga ON M6J 1X1

Sublingual Ketamine

Virtual supervision anywhere in Ontario

Patient Information				Physician Information			
First Name *		Last Name *		Physician's First Name **			
Address				Physician's Address			
Address 2				Physician's Address 2			
City		Prov.	Postal Code	Physician's City		Phys. Prov.	Phys. Postal Code
Phone Number *		E-Mail Address *		Billing Number *		Physician's Phone Number*	Fax Number *
Date of Birth (DD/MM/YY) *		Health Card *		Specialty *		Physician's E-Mail Address*	
Gender <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> OTHER				<input type="checkbox"/> FAMILY PHYSICIAN <input type="checkbox"/> PSYCHIATRIST			
Is the patient rostered into a group practice (FHO, FHT, etc)				<input type="checkbox"/> Yes		<input type="checkbox"/> No	
Reason for Referral: You would like your patient to be considered for (Check all that apply):							
<input type="checkbox"/> Ketamine <input type="checkbox"/> rTMS <input type="checkbox"/> Psilocybin							
Patient's Primary Diagnosis? *							
<input type="checkbox"/> Major Depression Disorder <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Post Traumatic Stress Disorder <input type="checkbox"/> Obsessive Compulsive Disorder <input type="checkbox"/> Personality Disorder <input type="checkbox"/> Other:							
Patient's Secondary Diagnosis? *							
<input type="checkbox"/> Major Depression Disorder <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Post Traumatic Stress Disorder <input type="checkbox"/> Obsessive Compulsive Disorder <input type="checkbox"/> Personality Disorder <input type="checkbox"/> Social Anxiety Disorder <input type="checkbox"/> Generalized Anxiety Disorder <input type="checkbox"/> Attention Deficit Hyperactivity Disorder <input type="checkbox"/> None <input type="checkbox"/> Other:							
Please describe the patient's current symptoms. *							
Please list any other current medical illnesses.							

SCAN FOR ONLINE REFERRAL FORM >>>





Please list ALL medication that the patient is CURRENTLY taking and their dosages. *

Please select the medications that the patient may have tried at some point in the past.

<input type="checkbox"/> Agomelatine	<input type="checkbox"/> Cytomel (T3)	<input type="checkbox"/> Levomilnacipran	<input type="checkbox"/> Oral Ketamine	<input type="checkbox"/> Suboxone
<input type="checkbox"/> Amitriptyline	<input type="checkbox"/> Desipramine	<input type="checkbox"/> Lithium	<input type="checkbox"/> Paliperidone	<input type="checkbox"/> Tranylcypromine
<input type="checkbox"/> Aripiprazole	<input type="checkbox"/> Desvenlafaxine	<input type="checkbox"/> Lurasidone	<input type="checkbox"/> Paroxetine	<input type="checkbox"/> Trazodone
<input type="checkbox"/> Benzodiazepines	<input type="checkbox"/> Divalproex	<input type="checkbox"/> Mianserin	<input type="checkbox"/> Phenezine	<input type="checkbox"/> Triiodothyronine
<input type="checkbox"/> Brexpiprazole	<input type="checkbox"/> Duloxetine	<input type="checkbox"/> Milnacipran	<input type="checkbox"/> Pregabalin	<input type="checkbox"/> Venlafaxine
<input type="checkbox"/> Bupropion	<input type="checkbox"/> Escitalopram	<input type="checkbox"/> Mirtazapine	<input type="checkbox"/> Quetiapine	<input type="checkbox"/> Vilazodone
<input type="checkbox"/> Buspar	<input type="checkbox"/> Fluoxetine	<input type="checkbox"/> Modafinil	<input type="checkbox"/> Risperidone	<input type="checkbox"/> Venlafaxine
<input type="checkbox"/> Cannabis	<input type="checkbox"/> Fluvoxamine	<input type="checkbox"/> Monoclobemide	<input type="checkbox"/> Selegiline transdermal	<input type="checkbox"/> Ziprasidone
<input type="checkbox"/> Carbamazepine	<input type="checkbox"/> Gabapentin	<input type="checkbox"/> Nasal Esketamine	<input type="checkbox"/> Sertraline	
<input type="checkbox"/> Caripiprazine	<input type="checkbox"/> IV Ketamine	<input type="checkbox"/> Nortriptyline	<input type="checkbox"/> Stimulants (e.g. methylphenidate, lisdexamfetamine, etc)	
<input type="checkbox"/> Citalopram	<input type="checkbox"/> Lamotrigine	<input type="checkbox"/> Olanzapine		

Has your patient ever had electroconvulsive therapy (ECT)? *

Yes No

Has your patient ever had transcranial magnetic stimulation (TMS)? *

Yes No

Has your patient ever been prescribed Ketamine or Esketamine by a healthcare provider for a mental disorder (e.g., major depressive disorder)? *

Yes No

Does your patient have a current/past history of alcohol use disorder or substance use disorder? *

Yes No

Has this patient been seen by a psychiatrist at MDPU/UHN/TWH in the past year that recommended ketamine (e.g., Dr. Rosenblat or Dr. McIntyre)? Please send notes if applicable *

Yes No Other

Is the patient receiving ongoing care from a psychiatrist? *

Yes No Referring physician is a psychiatrist

PLEASE SEND ALL PERTINENT CLINICAL SUMMARIES/LAB TESTS/PHYSICAL EXAM FINDINGS

I confirm that I am the patient's MRP and will be involved in this patient's care, providing ongoing psychiatric care leading up to and after the patient receives treatment at the CRTCE. The CRTCE will monitor the patient's psychiatric state during treatment and will consult with me, the referring physician, should it be deemed necessary. I will review notes and recommendations sent by the CRTCE for this patient. I understand that CRTCE is not able to provide ongoing psychiatric care.

Additional Documents Attached

Signature of Referring Physician

Date of Referral