

**Psychiatry Interventions Referral Form**

**Electroconvulsive Therapy (ECT), Ketamine, and Esketamine**

***Please complete and fax to 617-983-4688***

**Patient Information:**

|  |  |
| --- | --- |
| **Name** |  |
| **Date of Birth** |  |
| **Address** |  |
| **Phone Number** |  |
| **Insurance** |  |
| **Policy Number** |  |

**Reason for Referral (please indicate duration and severity of symptoms of major depressive disorder):**

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**Past Psychiatric History:**

|  |  |
| --- | --- |
| **Diagnosis/es (including personality disorders)** |  |
| **Hospitalizations** |  |
| **Suicide attempts** |  |
| **Self-harm behaviors** |  |
| **History of trauma** |  |
| **History of psychosis** |  |

**Current treaters:**

|  |  |  |
| --- | --- | --- |
| **Role** | **Name** | **Phone** |
| **Prescriber \*Note: active psychiatrist required\*** |  |  |
| **Therapist** |  |  |
| **Other** |  |  |

**Medication History:**

**Antidepressant trials**

**MUST INCLUDE Dose and Duration of treatment, inclusive of augmenting agents, as well as history of previous trials of ketamine and esketamine**:

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**Which combinations of medications have been tried during this episode of depression?**

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**ECT/TMS history:**

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**All Current Medications:**

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**Substance Use:**

**Is the patient currently using substances?** Yes No

**Has the patient demonstrated disordered substance use in the past 6 months?**

Yes No

**History of substance use disorder (if yes, please provide further details related to type of substance, duration of use, sobriety status):**

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**Past Medical History:**

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**In addition, please indicate if the patient has a history of the following**

Yes No **Hypertension**

Yes No **Aneurysmal vascular disease (including thoracic and abdominal aorta, intracranial and peripheral arterial vessels)**

Yes No **Arteriovenous malformation**

Yes No **Thyroid disease**

Yes No **Glaucoma**

Yes No **Liver dysfunction**

Yes No **Seizure disorder**

Yes No **Head trauma**

Yes No **Stroke or intracerebral hemorrhage**

Yes No **Pulmonary disease**

Yes No **Porphyria**

Yes No **Cardiac disease**

Yes No **Pregnancy**

**Is there a preference between ECT/ketamine/esketamine (and if so, which)?:**

ECT Ketamine Esketamine

**If considering ketamine, is the patient aware that the ketamine intravenous infusion may not be covered by insurance?** Yes No

**Ketamine and Esketamine Referrals ONLY: Is the patient aware that they may not drive home after the treatment and must have a responsible adult transport them or use or a livery service (taxi, Uber, Lyft or The Ride, etc.)?** Yes No

**ECT Referrals ONLY: Is the patient aware that they may not drive home after the treatment and must have a responsible adult to transport them home? Patients may not use a livery service (taxi, Uber, Lyft or The Ride, etc.) following ECT.** Yes No