KETAMINE/ESKETAMINE REFERRAL FORM

AWARE HUB
DR LISA MYERS

Referrals for esketamine/ ketamine treatment must be from the patient's own treating psychiatrist who will provide ongoing care[1, 2]

Please attach past letters, discharge summaries and report with details of psychiatric history and treatment. Please make sure all categories are completed prior to submission.

Referrer information

Psychiatrist Name: ……..… Provider Number: ……

Address: ……

Phone: …….. ☐ I confirm I will be providing ongoing care to this patient.

Patient Information

Name: ……..

DOB: ……/……/…… Age: …… Gender: ☐ Male ☐ Female ☐ Other

Address: ……..

Home Phone: …….. Mobile Phone: ……

Medical Details:

Hypertension	☐ Yes ☐ No	Current Alcohol or Drug Use	☐ Yes ☐ No
Urinary Bladder Conditions	☐ Yes ☐ No	Chronic Pain	☐ Yes ☐ No
Hepatic Disease	☐ Yes ☐ No	Cardiovascular Condition	☐ Yes ☐ No
Head Injury/Neurological Disorders	☐ Yes ☐ No	Past ketamine Use	☐ Yes ☐ No
Concussion	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	Hallucinations / Dissociation	☐ Yes ☐ No

If yes to any, please give details: ……

……..

……..

Other medical history, not listed above: ……..

……..

……..

Psychiatric Details

Major Depressive Disorder	☐ Yes ☐ No	Anxiety Disorder	☐ Yes ☐ No
Bipolar Disorder	☐ Yes ☐ No	PTSD	☐ Yes ☐ No
Schizophrenia	☐ Yes ☐ No	Mild Neurocognitive Disorder	☐ Yes ☐ No
Schizoaffective Disorder	☐ Yes ☐ No	Major Neurocognitive Disorder	☐ Yes ☐ No
Personality Disorder	☐ Yes ☐ No	OCD	☐ Yes ☐ No
Autism spectrum Disorder	☐ Yes ☐ No	Feeding and eating disorder	☐ Yes ☐ No

Ketamine/esketamine is provided for the therapy of Treatment Resistant Depression (TRD). Please give details of the TRD, including prior treatments and medications trialed, doses and duration of treatment. Past letters may also be attached.

Hospital admissions during the last 12 months ☐ No ☐ Yes

If yes, please attach discharge summaries

1.Ketamine/esketamine treatment is medically supervised by the Awarehub psychiatrist and registered nurse, but all patients must also have their own treating clinician who continues to provide primary care during the course of treatment. 2. In the case of esketamine treatment, a GP can provide the referral.

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Patient Name …….... DOB: ..… /..… /..…… Age: ..……

Address: …… Medicare Number:……

Suicide Risk: ☐ No ☐ Yes

Please attach safety plan and details if relevant ……..……..……

……..……

Drug Addiction or Dependence:

Is there any history of drug addiction or dependence (including alcohol)? ☐ No ☐ Yes

If yes, please provide details (drug, period and severity of dependence) ……..……

……..……

Has the patient been referred to or treated by Drug and Alcohol Services? ☐ No ☐ Yes

If yes, provide details of the D&A service provider and treatment. ……..……

……..……

Current Medications & Doses: (attach additional pages if required) ……..……

……..……

……..……

……..……

Allergies: ……..……

……..……

Physical Examination (please tick)
Psychiatrist may wish patient's GP to complete this section

	Normal	Abnormal		Normal	Abnormal
Neurological			Skin		
Chest			Head / Neck		
Heart			Eyes		
Lungs			ENT		
Abdomen			Extremities		

Overall Evaluation:

☐ Normal ☐ Abnormal summarise ABNORMAL findings below, including relevant results

……..……..……

……..……..……

……..……

LFTs within last 6 months required Results attached ☐ Yes ☐ No

MSU within last month required Results attached ☐ Yes ☐ No

ECG within the last month required Results attached

Please ensure that all categories are completed prior to submission.

Date: ..……/ ……./ …..……

Doctor's Name: ..... Signature: ……..…

Send all required documentation by Email to TMS@awarehub.com.au