MIND SIGHT CLINIC

REFERRAL FOR ESKETAMINE THERAPY

REFERRING PSYCHIATRIST

Name Provider Number

Address Email

Phone (02) Fax

Signature Date / / 20

Esketamine treatment is medically supervised but all patients must also have their own Psychiatrist who continues to provide primary care during the course of ketamine treatment.

PATIENT DETAILS

Title/First name Last name DOB

Street Address Suburb Postcode

Medicare Number Ref: Valid until:

DVA ☐ Workcover ☐

Preferred method of contact (Complete if your patient consents to our reception team contacting them directly to book an appointment)

☐ Mobile ☐ Email

Alternative contact (Complete if there is someone our reception team can contact if we are unable to reach the patient)

Name Relationship Phone number

Current General Practitioner (if known)

Name Practice

REFERRAL DETAILS

INDICATION FOR ESKETAMINE (MUST APPLY FOR REFERRAL TO BE CONSIDERED)

☐ Treatment resistant depression (failure to respond to at least two different antidepressants of adequate dose and duration)

Additional information (attach separate sheet if required)

Brief clinical summary (please outline a brief history of illness and treatment history including all previous antidepressants trialled, duration and doses if known)

Other psychiatric treatments trialled eg ECT, TMS, ketamine etc

Other psychiatric conditions present

Other medical conditions

- [ ] Hypertension
- [ ] Known vascular aneurysm (intracranial, abdominal, thoracic, other peripheral arterial)
- [ ] Past history of intracranial haemorrhage
- [ ] **None of the above**

PLEASE FAX YOUR REFERRAL TO (02) 9157 9033 or email to info@mindsightclinic.com.au