MINDSIGHT 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)

Antidepressants trialled previously _____

Other medications (please list all) _____

_____

Other psychiatric treatments _____

_____

Other psychiatric conditions _____

_____

_____

Other medical conditions

☐ Hypertension

☐ Known vascular aneurysm (intracranial, abdominal, thoracic, other peripheral arterial)

☐ Past history of intracranial haemorrhage

☐ Other _____

_____

Please fax referral to (02) 9157 9022 or email to info@mindsightclinic.com.au