16011 Airport Road, Caledon, ON L7C 1E7
Tel: 905-860-0866 I Fax: 866-580-8965
info@caledonclinic.ca

Patient Referral Form for Ketamine Treatment

Patient Information: (Patient must be 18 years of age or older)
First name: ________________________
Last Name: ________________________

Date of Birth: ________________________

Health Card Number: ________________________
Version Code: ________________________
☐No Version Code

Patient Phone Number: ________________________

Patient Email address: ________________________

Reason for Referral: ____
☐Treatment Resistant Depression
Other (Please Specify): ________________________

☐Urgent:
- ☐Patient was hospitalized for psychiatric care in the last month
- ☐Patient attempted suicide in the last month

Patient's Medical/Psychiatric History:
☐Copy of Cumulative Patient Profile (CPP) attached.
☐Relevant Investigations and Consultations attached.
☐Medication History attached.

Medications tried and not tolerated or not effective: Please select all that apply.
☐SNRI
☐SSRI
☐Atypical (Mirtazapine etc)
☐Tricyclic/Tetracyclic
☐Amphetamine

Medication History:
☐currently taking two anti-depressants:
☐unacceptable side effects (Please specify) ___________________________

Cardiovascular Risk:
☐my patient has an elevated cardiac risk
☐unsatisfactory control of hypertension
☐direct oral anticoagulant use
☐vitamin K antagonist (warfarin)
☐antiplatelet/antiaggregant

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Does your patient have any of the following?
☐ Alcohol use disorder ☐ Substance use disorder

Has your patient failed to respond to electroconvulsive therapy (ECT)?
☐Yes ☐No

Has your patient failed to respond to transcranial magnetic stimulation (TMS)?
☐Yes ☐No

Has your patient ever been prescribed Ketamine or Esketamine by a healthcare provider?
☐Yes ☐No

Has your patient receiving ongoing psychiatric care from a psychiatrist?
☐Yes ☐No

Social History:
☐Employed ☐Unemployed ☐ODSP ☐Other Source of Income: ____

Health Care Provider Information:
Referring MD/NP: ____
Billing number: ____
Phone: ____
Fax: ____

Please fax the completed form along with CPP and relevant investigations and consultation reports to Caledon Clinic at: 1 (866) 580-8965

Your patient will be contacted directly by Caledon Clinic to arrange an appointment. A consultation report will be faxed to your office after the consultation appointment.

Referring family physician please review and acknowledge:
I confirm that I am the patient's MRP and will be involved in this patient's care, providing ongoing care leading up to, during, and after this patient receives treatment at Caledon Clinic.
☐ I Confirm

__X ____

Signature

____
Print Name

____
Date