Clinician/Mental Health Professional Referral

PATIENT INFORMATION:

Name: ______________________________ DOB: _______________ Phone Number: _________________________

TREATING CLINICIAN OR MENTAL HEALTH PROFESSIONAL INFORMATION:

Name: ____ Specialty: _________________________

Email: _________________________ Phone No: ____________________ Fax No: _________________________

I am currently treating this patient for the following diagnos(es):

____

____

Patient's current psychiatric medications (you may attach a list if preferred):

____

____

Patient's previous psychiatric medications: (you may attach a list if preferred)

____

____

Do you believe this patient may have an active substance use disorder? ________________________

Please circle any of the following contraindications:

- Uncontrolled hypertension
- Unstable heart disease
- Untreated hyperthyroidism or tachycardia
- Raised intracranial or intraocular pressure
- Urinary incontinence, urgency or pain
- Pregnancy
- Psychosis, schizophrenia, current mania
- Seizure disorder
- Currently on lamotrigine (Lamictal) or regular benzodiazepine use
- MAOI antidepressant treatment

Music City Ketamine treatment protocol:

1. Patient will be contacted by our office for screening and scheduling. They will be provided with pre-procedure instructions.
2. We will check their mood throughout their weeks of treatment, and after the sixth infusion, we will determine whether ketamine has been effective for their treatment resistant depression. For the responders, maintenance infusions will be scheduled. On average, maintenance infusions are between 6 to 8 weeks.
3. We use an app-based program called Osmind to document their moods (www.osmind.org) and track progress.
4. We reach out and notify you about the patient's progress.

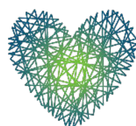
Please read the following and sign below:

- This patient and I would like to initiate ketamine infusion therapy as an adjunct to the management of the above illness.
- I acknowledge that I may review information about this therapeutic option at Music City Ketamine and that I may contact Music City Ketamine to discuss treatment.
- I will follow up with this patient during and after the completion of the treatment course at Music City Ketamine or refer them to a licensed medical professional for follow-up.

______________________________ ____________________

Clinician Signature Date

We appreciate the opportunity to collaborate with you in improving your patient's mental health.



Please return the completed form:

Mail: 480 Duke Dr., Suite #100 • Franklin, TN 37067

(615) 988-4600 • marla@musiccityketamine.com