Brigham and Women's Faulkner Hospital Ketamine/Esketamine Infusion Program Referral

Patient Information:

Name:
Birthday:
Address:
Phone Number:

Reason for Referral (please indicate duration and severity of symptoms of major depressive disorder):

Past Psychiatric History:

Diagnosis/es (including personality disorders):
Hospitalizations:
Suicide attempts:
Self-harm behaviors:
Antidepressant trials (please include dose and duration of treatment):

Which combinations of medications have been tried during this episode of depression?
ECT/TMS:
Previous ketamine trials (including for surgery) – if yes, please describe any hypersensitivity reaction:
History of psychosis:
History of trauma:
Psychiatrist:
Therapist:

Substance Use:

Currently abusing substances?
Has the patient demonstrated disordered substance use in the past 6 months?
History of substance use disorder (if yes, please provide further details related to type of substance, duration of use, sobriety status):

Current Medications:

Past Medical History:

In addition, does the patient has a history of hypertension, aneurysmal vascular disease (including thoracic and abdominal aorta, intracranial and peripheral arterial vessels),

arteriovenous malformation thyroid disease, glaucoma, liver dysfunction, seizure disorder, head trauma, stroke and intracerebral hemorrhage, pulmonary disease, porphyria, cardiac disease, or pregnancy:

Is the patient aware that the ketamine intravenous infusion may not be covered by insurance?

Is the patient aware that he/she/they may not drive home after the treatment and must have a friend or family member pick him/her/them up (i.e., not a livery service such as a taxi, Uber, or Lyft)?