Mass General Brigham
Brigham and Women's Faulkner Hospital

Psychiatry Interventions Referral Form

Electroconvulsive Therapy (ECT), Ketamine, and Esketamine

Please complete and fax to 617-983-4688

Patient Information:

Name	
Date of Birth	
Address	
Phone Number	
Insurance	
Policy Number	

Referral Source:

Name	
Phone Number	
Relation to Patient	

Reason for Referral (please indicate duration and severity of symptoms of major depressive disorder) NOTE: our clinic utilizes esketamine/ketamine for the treatment of treatment resistant major depressive episodes

Past Psychiatric History:

Diagnosis/es (including personality disorders)	
Hospitalizations	
Suicide attempts	
Self-harm behaviors	
History of trauma	
History of psychosis	
History of mania/hypomania NOTE: not eligible for Esketamine if positive	

Current treaters:

Role	Name	Phone
Prescriber		
Therapist		
Other		

Medication History:

Antidepressant trials: MUST INCLUDE Dose and Duration of treatment, inclusive of augmenting agents, as well as history of previous trials of ketamine and esketamine NOTE: patients require at least 4 failed antidepressant trials from 2 different classes to be authorized for esketamine/ketamine

Which combinations of medications have been tried during <u>this</u> episode of depression?

ECT/TMS history:

All Current Medications:

Substance Use:

NOTE: Patients with moderate-severe substance use disorders require at least 3 months of abstinence to be eligible for esketamine/ketamine

Is the patient currently using substances? ☐Yes ☐No

Has the patient demonstrated disordered substance use in the past 6 months?

☐Yes ☐No

History of substance use disorder (if yes, please provide further details related to type of substance, duration of use, sobriety status):

Past Medical History:

In addition, please indicate if the patient has a history of the following

☐Yes ☐No **Hypertension**

☐Yes ☐No **Aneurysmal vascular disease (including thoracic and abdominal aorta, intracranial and peripheral arterial vessels)**

☐Yes ☐No **Arteriovenous malformation**

☐Yes ☐No **Thyroid disease**

☐Yes ☐No **Glaucoma**

☐Yes ☐No **Liver dysfunction**

☐Yes ☐No **Seizure disorder**

☐Yes ☐No **Head trauma**

☐Yes ☐No **Stroke or intracerebral hemorrhage**

☐Yes ☐No **Pulmonary disease**

☐Yes ☐No **Porphyria**

☐Yes ☐No **Cardiac disease**

☐Yes ☐No **Pregnancy**

☐Yes ☐No **Metal in head/neck area**

☐Yes ☐No **Implanted devices (example: pacemaker)**

Is there a preference between ECT/ketamine/esketamine (and if so, which)?:

☐ECT ☐Ketamine ☐Esketamine

If considering ketamine, is the patient aware that the ketamine intravenous infusion may not be covered by insurance? ☐Yes ☐No

<u>Ketamine and Esketamine Referrals ONLY</u>: Is the patient aware that they may not drive home after the treatment and must have a responsible adult transport them or use or a livery service (taxi, Uber, Lyft or The Ride, etc.)? ☐Yes ☐No

<u>ECT Referrals ONLY</u>: Is the patient aware that they may not drive home after the treatment and must have a responsible adult to transport them home? Patients may not use a livery service (taxi, Uber, Lyft or The Ride, etc.) following ECT. ☐Yes ☐No