Patient Name:		Date:	
Contact No:		Contact:	
Ref By:			
*Treating Psychiatrist:		Contact:	

Thank you for your interest in the Georgia Ketamine Resistant Depression Clinic. Below is a brief description of the service:

The Treatment Resistant Depression (TRD) program is a consultation and referral service offering comprehensive evaluations for people who have complex and difficult-to-treat mood disorders. Patients are provided with an in-depth psychiatric consultation, including an extensive review of previous records, and detailed treatment recommendations. Patients are asked to bring a family member or close friend with them for this consultation.

Medications and continued follow-up care are provided by the referring psychiatrist

In order to refer your patient:

1. Attach the clinical note from the patients last visit
2. Attach a clinical Face Sheet with the patients demographics or fill out the demographics section below
3. Fax or Email referral form and information call: 855.438.5382
   Attn: Chris Fitzpatrick –chris.Fitzpatrick@georgiaketamine.com
4. If you have any questions, please contact: Chris Fitzpatrick-855.438.5382

**Missing information may delay scheduling*

Patient Demographics

Date of birth: _____ Sex: _____

Telephone: _____ Alt telephone: _____

O.K. to leave a voice message? _____

Email address: _____

Mailing address:

_____

_____

Emergency Contact: _____ Number: _____

Drivers License or Social Security Number: _____

How long have you known this patient?

Length of patient's current depressive episode?

Current Diagnosis/Diagnoses:

Current/Target Symptoms:

Past History of ECT ☐NO ☐YES

If YES, # of sessions: Type: ☐UL ☐BF ☐BT

Dates:

Past response: ☐excellent ☐good ☐fair ☐poor ☐unknown

Past History of TMS ☐NO ☐YES

If YES, # of sessions:

Dates:

Past response: ☐excellent ☐good ☐fair ☐poor ☐unknown

Past History of Ketamine? ☐NO ☐YES -If YES: ☐IV Ketamine ☐Nasal Ketamine

Past History of Substance Abuse? ☐NO ☐YES

☐ In remission ☐ Active substance Use

Please Describe:

Current Medications:

Are you referring the patient for a specific treatment option? ☐Ketamine ☐TMS ☐ECT ☐Other

Do we have permission to contact the patient? ☐NO ☐YES

ADDITIONAL NOTES

Clinical Impression :

Treating Psychiatrist Signature

Date