



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](mailto: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:

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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?

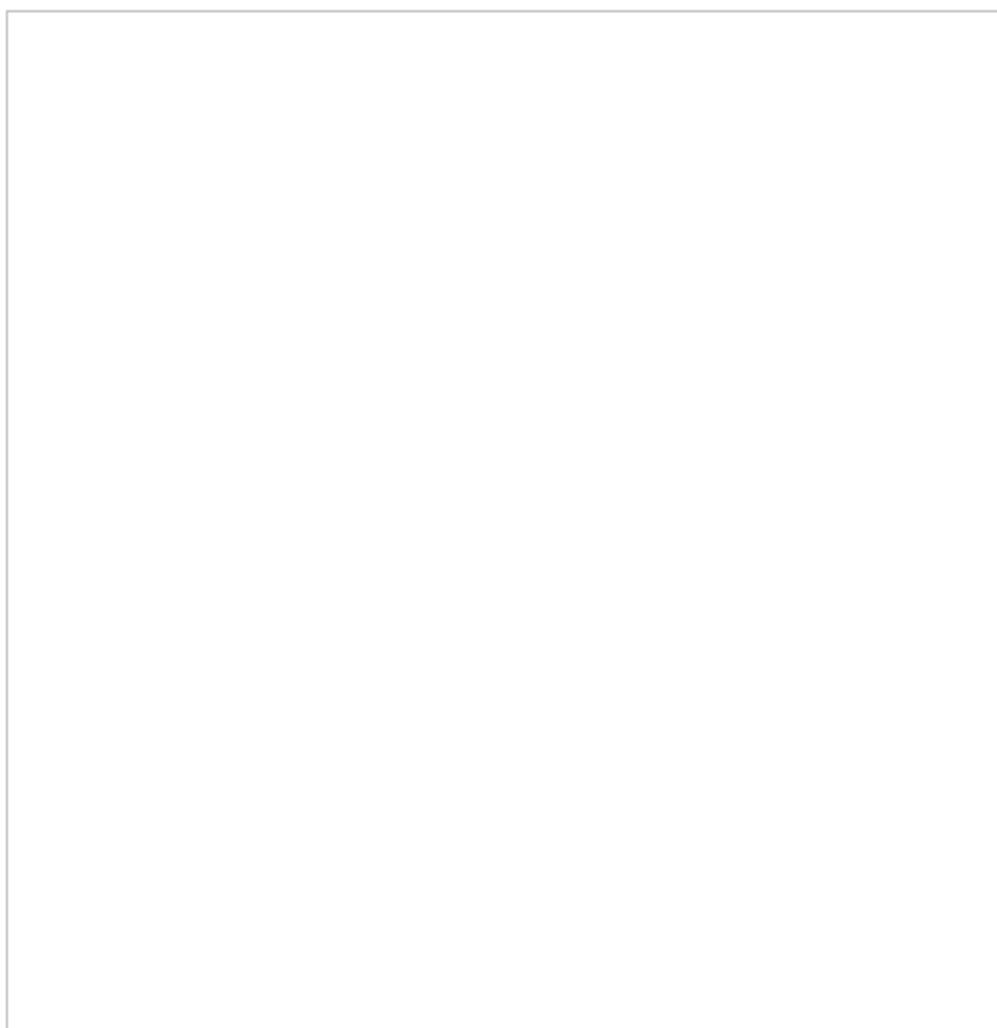
Ketamine TMS ECT Other

Do we have permission to  
contact the patient?

NO YES

**ADDITIONAL NOTES**

Clinical Impression :



\_\_\_\_\_  
Treating Psychiatrist Signature

\_\_\_\_\_  
Date