1-1171 Bedford Hwy, Bedford NS
902.466.ANSR (2677)
902.455.ANSR (2677)

KETAMINE REFERRAL FORM
PLEASE FAX TO 902-455-2677

Patient Information

Full Name: _____ _____ **DOB:**_____
Last First

Address: _____ _____ **Phone:**_____
Street City

History	
Indication for Ketamine:	**Current Medications and doses:**
(please check all that apply):	
☐ **Major Depressive Disorder**	
☐ **Posttraumatic Stress Disorder**	**Past Medication Trials/ECT/rTMS/other:**
☐ **Chronic Pain Syndrome**	
☐ **Bipolar II disorder**	
☐ **Other:**	

Brief Clinical History

Potential Contraindications to Ketamine		
☐ **Current psychotic depression**	☐ **Allergy to Ketamine**	
☐ **History of substance dependence/abuse**	☐ **Dementia**	
☐ **Severe personality disorder**	☐ **Current illicit substance use**	
☐ **Recent history of psychosis**	☐ **Unstable Medical Disorder**	
☐ **Uncontrolled Hypertension**		
☐ **Cerebral Aneurysm**	☐ **Pregnancy/breastfeeding**	
If yes to any of the above please elaborate to the right:		

Are you referring for treatment with:	☐ ***IM Ketamine***	☐ ***Intranasal Ketamine***	☐ ***Either route***

Physician Information

Name: _____ **Signature:** _____

Date: _____ **Phone:** _____