Emily Garber APRN PLLC
Spravato Referral Form

Client Name: _____ **DOB:** _____ **Phone:** _____

Referring Provider: _____ **Spravato Provider:** _____ **Primary DX:** _____

Primary Insurance: _____ **Secondary Insurance:** _____

CURRENT MEDICATIONS & DOSAGES:

1.	**2.**	**3.**
4.	**5.**	**6.**

FOUR OR MORE FAILED APPROVED ANTIDEPRESSANT TRIALS AND TWO AUGMENTING AGENTS:

ANTIDEPRESSANT	DOSE	DURATION	SIDE EFFECTS		TRIAL SUCCESSFUL	
			YES & DETAILS	NO	YES	NO
AUGMENTING AGENT	**DOSE**	**DURATION**	**SIDE EFFECTS**	**NO**	**YES**	**NO**

PHQ-9 DEPRESSION SCALE HISTORY:

Date	Score	Date	Score	Date	Score

THERAPY HX:

TREATING THERAPIST	TYPE OF THERAPY	SCHEDULE	DURATION	SUCCESSFUL "Y" OR "N"	WHY TX WAS INEFFECTIVE
		W☐ Bi☐ M☐			

Extenuating Circumstances: _____

_____

Decline in Functioning: _____

_____

Hospitalizations: **YES☐ NO☐** If yes; details: _____

Drug /Alcohol Use: **YES☐ NO☐** If yes; details: _____

ECT HX: **YES☐ NO☐** If yes; date of TX & details: _____

TMS HX: **YES☐ NO☐** If yes; date of TX & details: _____

PLEASE CHECK OFF ANY OF THE FOLLOWING THAT THE PATIENT HAS EXPERIENCED IN THE PAST:

	DOES THE PATIENT HAVE A HISTORY OF ANEURYSMAL VASCULAR DISEASE OR A HISTORY OF BRAIN BLEED?
	HAS THE PATIENT EXPERIENCED AN ALLERGIC REACTION TO ESKETAMINE OR KETAMINE?
	IS THE PATIENT PREGNANT/NURSING OR PLAN ON BECOMING PREGNANT?
	DOES THE PATIENT HAVE A HISTORY OF HEART/BRAIN/LIVER PROBLEMS? HYPERTENSION, IRREGULAR HEART RATE, HEART ATTACK, STROKE, HEART FAILURE, BRAIN INJURY, EPILEPSY, SEIZURE, LIVER FAILURE, CIRRHOSIS.
	HAS THE PATIENT EVER SUFFERED FROM A PSYCHOSIS?
	THE PATIENT HAS NONE OF THE FOLLOWING EXCLUSIONARY RESTRICTIONS AND MEETS CRITERIA FOR TREATMENT:

REFERRING PROVIDER SIGNATURE: _____ **DATE** _____

SPRAVATO PROVIDER SIGNATURE: _____ **DATE** _____