1-1171 Bedford Highway
Bedford, NS B4A 1C2
Tel: 902-466-ANSR (2677)
Fax: 902-455-ANSR (2677)
info@ansrclinic.com

KETAMINE REFERRAL FORM

Fax to: 902-455-2677
Email to: info@ansrclinic.com

PATIENT INFORMATION

FIRST NAME | LAST NAME | DATE OF BIRTH (DD/MM/YYYY)

ADDRESS | CITY | PROVINCE | POSTAL CODE

PHONE # (CELL) | PHONE # (HOME) | EMAIL ADDRESS

VETERAN ID OR HEALTH CARD # | PATIENT CARETAKER (IF APPLICABLE)

MEDICAL HISTORY

INDICATIONS FOR KETAMINE:
(Please check all that apply)

- ☐ Major Depressive Disorder
- ☐ Bipolar Depression
- ☐ Posttraumatic Stress Disorder
- ☐ Other:

CURRENT MEDICATIONS AND DOSES: ☐ NONE

PAST MEDICATION TRIALS/ECT/rTMS/Other:

BRIEF CLINICAL HISTORY

POTENTIAL CONTRADICTIONS TO KETAMINE

☐ Current Psychotic Depression	☐ Recent History of Psychosis	☐ Dementia
☐ History of Substance Dependence/Abuse	☐ Uncontrolled Hypertension	☐ Current Illicit Substance Use
☐ Severe Personality Disorder	☐ Cerebral aneurysm	☐ Unstable Medical Disorder
	☐ Allergy to Ketamine	☐ Pregnancy/Breastfeeding

If yes to any of the above, please elaborate:

Are you referring for treatment with: ☐ IM Ketamine ☐ Intranasal Ketamine ☐ Either Route
(please check one)

PHYSICIAN / NP INFORMATION

NAME | SIGNATURE

DATE | PHONE #