ANSR
Atlantic Neuromod Solutions and Rehabilitation

ansr.ca

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KETAMINE REFERRAL FORM

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)

PREFERRED LOCATION: ☐ Bedford ☐ Sydney ☐ Wolfville ☐ Fredericton ☐ St. John's ☐ Edmonton ☐ Calgary

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: ☐ NONE

BRIEF CLINICAL HISTORY (please included any known allergies)

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:

Treatment Referring For: ☐ IM Ketamine ☐ Intranasal Ketamine ☐ IV Ketamine
(please check one)

PHYSICIAN / NP INFORMATION

NAME | SIGNATURE

DATE | PHONE #