BRAXÍA HEALTH

PHYSICIAN REFERRAL FORM

FAX TO: 1-877-919-0861

PATIENTS WILL BE EVALUATED FOR ALL PROGRAMS

☐ **IV Ketamine (Adult)**
1100 Dundas Street W.
Unit # 7/8
Mississauga ON M6J 1X1

☐ **Sublingual Ketamine (Adult)**
Virtual supervision anywhere in Ontario

☐ **Adolescent Ketamine (15-17 years)**
Sublingual in-clinic ONLY
1100 Dundas Street W. Unit # 7/8
Mississauga ON M6J 1X1

Patient Information			Physician Information		
First Name *	Last Name *		Physician's First Name * / Physician's Last Name *		
Address			Physician's Address		
Address 2			Physician's Address 2		
City	Prov.	Postal Code	Physician's City	Phys. Prov.	Phys. Postal Code
Phone Number *	E-Mail Address *		Billing Number *	Physician's Phone Number*	Fax Number *
Date of Birth (DD/MM/YY) *	Health Card *		Specialty *	Physician's E-Mail Address*	
Gender ☐ MALE ☐ FEMALE ☐ OTHER			☐ FAMILY PHYSICIAN	☐ PSYCHIATRIST	

Is the patient rostered into a group practice (FHO, FHT, etc) ☐ Yes ☐ No

Patient's Primary Diagnosis? *

☐ Major Depression Disorder ☐ Bipolar Disorder ☐ Post Traumatic Stress Disorder ☐ Obsessive Compulsive Disorder ☐ Personality Disorder
☐ Other:

Patient's Secondary Diagnosis? *

☐ Major Depression Disorder ☐ Bipolar Disorder ☐ Post Traumatic Stress Disorder ☐ Obsessive Compulsive Disorder ☐ Personality Disorder
☐ Social Anxiety Disorder ☐ Generalized Anxiety Disorder ☐ Attention Deficit Hyperactivity Disorder
☐ None ☐ Other:

Please describe the patient's current symptoms. *

Please list any other current medical illnesses.

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Please list ALL medication that the patient is CURRENTLY taking and their dosages. *

Please select the medications that the patient may have tried at some point in the past.

- ☐ Agomelatine
- ☐ Amitriptyline
- ☐ Aripiprazole
- ☐ Benzodiazepines
- ☐ Brexpiprazole
- ☐ Bupropion
- ☐ Buspar
- ☐ Cannabis
- ☐ Carbamazepine
- ☐ Caripiprazine
- ☐ Citalopram
- ☐ Cytomel (T3)
- ☐ Desipramine
- ☐ Desvenlafaxine
- ☐ Divalproex
- ☐ Duloxetine
- ☐ Escitalopram
- ☐ Fluoxetine
- ☐ Fluvoxamine
- ☐ Gabapentin
- ☐ IV Ketamine
- ☐ Lamotrigine
- ☐ Levomilnacipran
- ☐ Lithium
- ☐ Lurasidone
- ☐ Mianserin
- ☐ Milnacipran
- ☐ Mirtazapine
- ☐ Modafinil
- ☐ Monoclobemide
- ☐ Nasal Esketamine
- ☐ Nortriptyline
- ☐ Olanzapine
- ☐ Oral Ketamine
- ☐ Paliperidone
- ☐ Paroxetine
- ☐ Phenelzine
- ☐ Pregabalin
- ☐ Quetiapine
- ☐ Reboxetine
- ☐ Risperidone
- ☐ Selegiline transdermal
- ☐ Sertraline
- ☐ Stimulants (e.g. methylphenidate, lisdexamfetamine, etc)
- ☐ Suboxone
- ☐ Tranylcypromine
- ☐ Trazodone
- ☐ Triiodothyronine
- ☐ Venlafaxine
- ☐ Vilazodone
- ☐ Vortioxetine
- ☐ Vyvanse
- ☐ Ziprasidone

Has your patient ever had electroconvulsive therapy (ECT)? *

☐ Yes ☐ No

Has your patient ever had transcranial magnetic stimulation (TMS)? *

☐ Yes ☐ No

Has your patient ever been prescribed Ketamine or Esketamine by a healthcare provider for a mental disorder (e.g., major depressive disorder)? *

☐ Yes ☐ No

Does your patient have a current/past history of alcohol use disorder or substance use disorder? *

☐ Yes ☐ No

Has this patient been seen by a psychiatrist at MDPU/UHN/TWH in the past year that recommended ketamine (e.g., Dr. Rosenblat or Dr. McIntyre)? Please send notes if applicable *

☐ Yes ☐ No ☐ Other

Is the patient receiving ongoing care from a psychiatrist? *

☐ Yes ☐ No ☐ Referring physician is a psychiatrist

PLEASE SEND ALL PERTINENT CLINICAL SUMMARIES/LAB TESTS/PHYSICAL EXAM FINDINGS

I confirm that I am the patient's MRP and will be involved in this patient's care, providing ongoing psychiatric care leading up to and after the patient receives treatment at the CRTCE. The CRTCE will monitor the patient's psychiatric state during treatment and will consult with me, the referring physician, should it be deemed necessary. I will review notes and recommendations sent by the CRTCE for this patient. I understand that CRTCE is not able to provide ongoing psychiatric care.

Additional Documents Attached ☐

Signature of Referring Physician

Date of Referral

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