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SPRAVATO™ (esketamine) for Treatment-Resistant Depression (TRD) Patient Referral Form

(Please complete and fax to: 281-398-9823. For questions please call: 281-398-9800)

Patient's Information

Name: _____ Date of Birth: _____

Sex: Male ( ) Female ( ) Patient's Phone Number: _____

Reason for referral: _____

DSM 5 diagnosis: _____ ICD-10 Code: _____

Brief Psychiatric History: _____

_____

_____

Suicidal History: Yes ( ) No ( ) _____

Chemical Substance Abuse: Not applicable ( ) In remission ( ) Ongoing ( )

(Patients with ongoing chemical substance abuse do not qualify for Spravato treatment)

Past Ketamine or Esketamine Trials: _____

_____

Patient's Authorization for PMP Report and Urine Drug Screen (UDS) Testing

A Prescription Monitoring Program report for all Controlled Substances will be obtained for this patient. We may ask the patient to provide a sample for UDS testing.

Patient's full signature: _____ Date: _____

Referring Doctor's Information

Doctor's Name: _____ Title/Specialty_____

Phone: _____ Fax: _____ Email: _____

Doctor's Signature: (NO STAMP SIGNATURES) _____

PATIENT'S ANTIDEPRESSANT MEDICATION HISTORY

Generic Name	Medication Dates (month/year)
SSRIs	
Citalopram	/ to /
Escitalopram	/ to /
Fluoxetine	/ to /
Fluvoxamine	/ to /
Paroxetine	/ to /
Sertraline	/ to /
SNRIs	
Venlafaxine	/ to /
Desvenlafaxine	/ to /
Serotonin modulator	
Vortioxetine	/ to /
Noradrenaline reuptake inhibitors	
Reboxetine	/ to /
TCAs	
Amitriptyline	/ to /
Nortriptyline	/ to /
Clomipramine	/ to /
Dothiepin	/ to /
Doxepin	/ to /
Imipramine	/ to /

Trimipramine	/ to /

RIMAs (reversible inhibitors of monoamine oxidase A)

Moclobemide	/ to /

Noradrenergic Specific Serotonergic Antidepressant (NaSSA)

Mirtazapine	/ to /

MAOIs (monoamine oxidase inhibitors)

Tranylcypromine	/ to /
Phenelzine	/ to /

Melatonergic antidepressants

Agomelatine	/ to /

FOR DR. GUERRERO'S OFFICE USE ONLY

Dr. Guerrero will review this referral and authorize Spravato treatment for this patient

Spravato treatment approved: Yes ( ) No ( ) _____

UDS testing required: Yes ( ) No ( ) _____

Dr. Guerrero's Signature: _____ Date: _____

	✓	Staff Initials	Comment
Patient was verified with referring office			
Texas PMP report was obtained			
Patient scheduled for treatment here			Appointment date/time: