MARQUETTE MEDICAL URGENT + CARE

1025 W Washington St, Suite A, Marquette, MI 49855
Phone: (906)239-5050, Fax: (906)239-5055

Referral For Ketamine Infusion Therapy

Contraindications: uncontrolled hypertension, angina, severe respiratory illnesses, or anything that would be considered a risk for outpatient procedures. Chronic use of high doses of benzodiazepine also may impact response to Ketamine.

Please fax completed form, latest progress note, and patient demographics to 906.239.5055

REFERRING CLINICIAN	
Provider Name:	Practice/Clinic Name:
Phone:	Fax:

PATIENT DEMOGRAPHICS:			
Name:	DOB:	Birth Sex:	Pronouns/ Pref. Name:
Address/ City/ State/ Zip:	Phone:		
	Email:		

PATIENT HISTORY:	
Major Depressive Disorder: [ ] **Generalized Anxiety Disorder: [ ]** **Substance Use Disorder: [ ]** **Bipolar Disorder: [ ]**	**Postpartum Depression: [ ]** **OCD: [ ]** **PTSD: [ ]**
Additional Psychiatric Diagnoses: PHQ9 Score (If Known):	**Medical history of:** **Uncontrolled HTN [ ]** **Aneurysm in any location [ ]** **Ocular surgery or glaucoma [ ]** **Unstable angina [ ]** **Severe respiratory illness [ ]**
History of Psychotherapy: [ ] Yes [ ] No	Psychotherapy Dates:

Failed Medications Used for Depression in the Past Year:	Max Dose Used	Start Date	Stop Date	Response	Discontinued for side effects/lack of efficacy?
				None [ ] Partial [ ] Transient [ ]	
				None [ ] Partial [ ] Transient [ ]	
				None [ ] Partial [ ] Transient [ ]	

Provide a summary of previous Ketamine, TMS or ECT treatments, if applicable. Please include dates and numbers of treatments, responses and/or complications.

History of Psychiatric Admissions, Suicide Attemps, Psychotic Episodes, and Substance Use Disorder:

Provider Name:_____

Provider Signature:_____ Date:_____