Orillia Ketamine Clinic
17 Colborne St. E Unit 104
Orillia, ON. L3V 1T4
Tel: 705-327-7070
Fax: 877-503-6584

Referral Form

Patient Information: (Patient must be 18 years of age or older)
First name: _____
Last Name: _____

Date of Birth: _____

Health Card Number: _____
Version Code: _____
☐No Version Code

Patient Phone Number: _____

Patient Email address: _____

Reason for Referral: _____
☐Treatment Resistant Depression
Other (Please Specify): _____

☐Urgent:
- ☐Patient was hospitalized for psychiatric care in the last month
- ☐Patient attempted suicide in the last month

Patient's Medical/Psychiatric History:
☐Copy of Cumulative Patient Profile (CPP) attached.
☐Relevant Investigations and Consultations attached.
☐Medication History attached.

Medications tried and not tolerated or not effective: Please select all that apply.
☐SNRI
☐SSRI
☐Atypical (Mirtazapine etc)
☐Tricyclic/Tetracyclic
☐Amphetamine

Medication History:
☐currently taking two anti-depressants:
☐unacceptable side effects (Please specify) _____

Cardiovascular Risk:
☐my patient has an elevated cardiac risk
☐unsatisfactory control of hypertension
☐direct oral anticoagulant use
☐vitamin K antagonist (warfarin)
☐antiplatelet/antiaggregant

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Does your patient have any of the following?
☐ Alcohol use disorder ☐ Substance use disorder

Has your patient failed to respond to electroconvulsive therapy (ECT)?
☐Yes ☐No

Has your patient failed to respond to transcranial magnetic stimulation (TMS)?
☐Yes ☐No

Has your patient ever been prescribed Ketamine or Esketamine by a healthcare provider?
☐Yes ☐No

Is your patient receiving ongoing psychiatric care from a psychiatrist?
☐Yes ☐No

Social History:
☐Employed ☐Unemployed ☐ODSP ☐Other Source of Income: _____

Health Care Provider Information:
Referring MD/NP: _____
Billing number: _____
Phone: _____
Fax: _____

Please fax the completed form along with CPP and relevant investigations and consultation reports to Orillia Ketamine Clinic at: 877-503-6584

Your patient will be contacted directly by Orillia Ketamine Clinic to arrange an appointment. A consultation report will be faxed to your office after the consultation appointment.

Referring physician please review and acknowledge:
I confirm that I am the patient's physician and will be involved in this patient's care, providing ongoing care leading up to, during, and after this patient receives treatment at Orillia Ketamine Clinic.
☐ I Confirm

X _____

Signature

_____
Print Name

_____
Date