Interventional Psychiatry Referral Form (TMS / Spravato / Ketamine Evaluation)

1. Patient Information
Name: _____ DOB: _____
Phone: _____ Email: _____
Insurance: _____

2. Referring Provider Information
Provider Name: _____
Practice: _____
Phone: _____ Fax: _____
NPI: _____

3. Diagnosis and Severity
Diagnosis: _____ ICD-10: _____
Severity: ■ Moderate ■ Severe
Baseline Score (PHQ-9/MADRS): _____

4. Treatment History
■ Multiple Medication Failures
■ Medication Intolerance
■ Failed Psychotherapy
■ Prior Hospitalization
■ Suicide Ideation

5. Which Service Are You Referring For?
■ TMS
■ Spravato
■ Ketamine
■ Evaluation to determine best treatment option

6. Contraindications Checklist
Seizure History: ■ Yes ■ No
Metal in Head: ■ Yes ■ No
Uncontrolled BP: ■ Yes ■ No
Substance Use Disorder: ■ Yes ■ No

7. Required Documents
■ Psychiatric Evaluation
■ Medication History
■ Depression Rating Scale
■ Insurance Card

■ Progress Notes

8. Referring Provider Signature
Signature: _____ Date: _____