

Spravato (Esketamine) Referral Form

1. Patient Information

Name: _____ DOB: _____
Phone: _____ Email: _____
Insurance: _____ ID#: _____

2. Referring Provider Information

Provider Name: _____
Practice: _____
Phone: _____ Fax: _____
NPI: _____

3. Diagnosis (Required)

Primary Diagnosis: _____ ICD-10: _____
 Major Depressive Disorder Bipolar Depression
Severity: Moderate Severe
Baseline Score (PHQ-9 or MADRS): _____ Date: _____

4. Medication Trials (Required)

List at least 2 antidepressant failures:
Medication | Dose | Dates | Response

5. Current Medications

6. Safety Screening

Uncontrolled Hypertension: Yes No
Aneurysm/AVM: Yes No
History of Psychosis: Yes No
Substance Use Concerns: Yes No

7. Required Documents

Psychiatric Evaluation
 Medication History
 Depression Rating Scale
 Insurance Card
 Recent Progress Notes

8. Referring Provider Signature

Signature: _____ Date: _____