**Intranasal Esketamine**

**Internal Patient Referral**

**Patient Information***To be completed by internal referring provider.*

Patient Name:

Date of Birth:

Medical Record Number:

**Referral Information***To be completed by internal referring provider.*

Referring Provider Name:

Office Phone Number: Office Fax:

Referral Diagnosis: [ ] F32.2, Major depressive disorder, single episode, severe without psychotic features
 [ ] F33, Recurrent depressive disorder
 [ ] Other:

If a single episode MDD is the duration > or = 2 years? [ ]  Yes [ ]  No

If recurrent MDD is there inadequate response to 2 different antidepressants [ ]  Yes [ ]  No

Antidepressant #1\_\_\_\_\_\_\_\_\_\_\_\_ Dose \_\_\_\_\_\_\_\_\_Duration \_\_\_\_\_\_\_\_\_ Outcome\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Antidepressant #2\_\_\_\_\_\_\_\_\_\_\_\_ Dose \_\_\_\_\_\_\_\_\_Duration \_\_\_\_\_\_\_\_\_ Outcome\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the patient have a history of substance abuse? [ ]  No [ ]  Yes, if so where/what:

Has the patient had prior ECT? [ ]  No [ ]  Yes, if so where/when:

Has the patient had prior TMS? [ ]  No [ ]  Yes, if so where/when:

Has the patient had prior treatment with ketamine? [ ]  No [ ]  Yes, if so where/when:

Has the patient had vagal nerve stimulation? [ ]  No [ ]  Yes, if so where/when:

***Please Email to:***

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