**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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