**Intranasal Esketamine**

**New Patient Information**

**Patient Information** *To be completed by patient*

Last Name: Middle: First Name:

Date of Birth: Phone: Email:

Gender:  Male  Female  Nonbinary Preferred Pronouns: He/Him  She/Her They/Them

Relationship Status:  Single  Married  Divorced  Widowed  Partner

Race/Ethnicity: Caucasian African American Hispanic Asian Native American Other:

Address       Apt #

City       State       Zip

**Primary Insurance Information** *To be completed by patient*

Insurance Provider: Insurance Policy Holder:

Insurance Number: Group Number:

Relationship to Policy Holder: Policy Holder DOB:

**Referring Provider***To be completed by patient.*

Referring Provider Name:

Phone Number: Office Fax:

Email Address:

SAFETY SCREEN FOR ESKETAMINE CANDIDATES

*To be completed by patient, to the best of your knowledge*

|  |  |  |
| --- | --- | --- |
| **Question:** | ***Please check the appropriate box.*** | |
| Do you have an allergy to ketamine? | Yes | No |
| Do you have increased blood pressure? | Yes | No |
| Are you or have you had suicidal thoughts, plans or actions ? If yes, please describe event(s): | Yes | No |
| Have you ever been diagnosed with an aneurysm of the thoracic or abdominal? If yes, please describe event(s): | Yes | No |
| Have you ever been diagnosed with an intracranial aneurysm? If yes, please describe event(s): | Yes | No |
| Have you ever been diagnosed with a peripheral arterial aneurysm? If yes, please describe event(s): | Yes | No |
| Are you pregnant or is there a chance that you might be? | Yes | No |
| Are you breast-feeding? | Yes | No |
| Are you using contraception currently? If yes, please describe: | Yes | No |
| Do you have problems with nausea? If yes, please describe: | Yes | No |
| Do you have problems with nausea? If yes, please describe: | Yes | No |

***Fax or Mail to:***

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Chapel Hill, North Carolina 27514

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Fax: (984)-974- 9646