UCLA TMS
Clinical and Research Service

ORAL KETAMINE TREATMENT REFERRAL FORM

Date: _____

Patient Name: _____

Patient DOB: _____ Patient Phone: _____

Diagnosis:
- ☐ Major Depressive Disorder
- ☐ Bipolar I Disorder, current episode depressed
- ☐ Bipolar II Disorder, current episode depressed

Referring Provider: _____

NPI: _____ Fax or Email: _____

Direct phone: _____

Preferred Contact: ☐ Email ☐ Fax ☐ Phone

PLEASE NOTE:

Patients referred for oral ketamine treatment at UCLA will be scheduled for a telehealth evaluation. This visit involves both screening for safety and appropriateness of oral ketamine treatment, and discussion of the risks, benefits, and alternatives to oral ketamine treatment.

After this evaluation, if your patient is not eligible for oral ketamine or declines oral ketamine treatment, you will be contacted.

Eligible patients who elect to proceed with oral ketamine will be prescribed an initial "test dose" of oral ketamine, which is administered in our clinic. This visit involves 2-3 hours of monitoring to establish the safety and tolerability of oral ketamine for home use. After this test dose, our team will reach out to you to discuss the tolerability and recommended home dosing of ketamine for your patient. We are happy to guide you through the process and we remain available to providers for consultation, but ***the referring psychiatrist prescribes and manages ketamine from that time onward.*** By submitting this referral, you indicate that you understand and agree to this.

Signature of Referring Provider:

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