



Connecticut Behavioral Health Associates, P. C.

SPRAVATO REFERRAL FORM

Client Name: _____ DOB: _____ Phone: _____

Referring Provider: _____ Spravato Provider: _____ Primary DX: _____

Primary Insurance: _____ Secondary Insurance: _____

CURRENT MEDICATIONS & DOSAGES:

1. _____	2. _____	3. _____
4. _____	5. _____	6. _____

FOUR OR MORE FAILED APPROVED ANTIDEPRESSANT TRIALS AND TWO AUGMENTING AGENTS:

ANTIDEPRESSANT	DOSE	DURATION	SIDE EFFECTS		TRIAL SUCCESSFUL		
			YES & DETAILS	NO	YES	NO	
AUGMENTING AGENT	DOSE	DURATION	SIDE EFFECTS		NO	YES	NO

PHQ-9 DEPRESSION SCALE HISTORY:

Date	Score	Date	Score	Date	Score

THERAPY HX:

TREATING THERAPIST	TYPE OF THERAPY	SCHEDULE	DURATION	SUCCESSFUL "Y" OR "N"	WHY TX WAS INEFFECTIVE
		W <input type="checkbox"/> Bi <input type="checkbox"/> M <input type="checkbox"/>			

Extenuating Circumstances: _____

Decline in Functioning: _____

Hospitalizations: YES NO If yes; details: _____

Drug /Alcohol Use: YES NO If yes; details: _____

ECT HX: YES NO If yes; date of TX & details: _____

TMS HX: YES NO If yes; date of TX & details: _____

PLEASE CHECK OFF ANY OF THE FOLLOWING THAT THE PATIENT HAS EXPERIENCED IN THE PAST:

<input type="checkbox"/>	DOES THE PATIENT HAVE A HISTORY OF ANEURYSMAL VASCULAR DISEASE OR A HISTORY OF BRAIN BLEED?
<input type="checkbox"/>	HAS THE PATIENT EXPERIENCED AN ALLERGIC REACTION TO ESKETAMINE OR KETAMINE?
<input type="checkbox"/>	IS THE PATIENT PREGNANT/NURSING OR PLAN ON BECOMING PREGNANT?
<input type="checkbox"/>	DOES THE PATIENT HAVE A HISTORY OF HEART/BRAIN/LIVER PROBLEMS? HYPERTENSION, IRREGULAR HEART RATE, HEART ATTACK, STROKE, HEART FAILURE, BRAIN INJURY, EPILEPSY, SEIZURE, LIVER FAILURE, CIRRHOSIS.
<input type="checkbox"/>	HAS THE PATIENT EVER SUFFERED FROM A PSYCHOSIS?
<input type="checkbox"/>	THE PATIENT HAS NONE OF THE FOLLOWING EXCLUSIONARY RESTRICTIONS AND MEETS CRITERIA FOR TREATMENT:

REFERRING PROVIDER SIGNATURE: _____ DATE _____

SPRAVATO PROVIDER SIGNATURE: _____ DATE _____