Solaris Integrative Psychiatry, Ltd
1302 S Shields St., Unit A2-4
Fort Collins, CO 80521
Phone: (970) 676-3370
Fax: (970) 591-9606

PATIENT REFERRAL FOR SPRAVATO® and/or KETAMINE TREATMENT

PATIENT INFORMATION

Referral is regarding: ☐ SPRAVATO® Treatment ☐ IM Ketamine Treatment ☐ Either Treatment Modality

First Name: ______________ Last Name: ______________ Date of Birth: ______________

Street Address: ______________ Phone Number: ______________

City: ______________ State: ________ Zip Code: ________ Email: ______________

*May we leave a voicemail and/or email the client to schedule an appointment? ☐ Yes - Phone ☐ Yes - Email ☐ No

Primary Insurance: ______________ Policy Number: ______________ Group Number: ______________

Policyholder Name: ______________ Card Number/BIN: ______________

MEDICAL HISTORY

DSM Diagnosis/es:

____

____

Current Medications:

____

Antidepressant Trial History:
please include dose and duration of each tried medication

____

Does the patient have/have history of any of the following? (Please check all that apply):

☐ Hypertension ☐ Interstitial Cystitis ☐ Known sensitivity to ketamine or its derivatives
☐ Mania/hypomania ☐ Psychosis ☐ Cognitive impairment
☐ Substance abuse ☐ Vascular disease ☐ Arterial venous malformation
☐ Aneurysm ☐ Intracerebral hemorrhage ☐ Other cardiovascular disease

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REFERRING PROVIDER INFORMATION

Referring Healthcare Provider Name/Credentials: ______________________ Phone Number ______________

Street Address: ______________________ Fax Number: ______________

City: ______________ State: ______ Zip Code: ______ Email: ______________

This referral is specifically for treatment with SPRAVATO® and/or ketamine. Please ensure that you and your patient are aware of the following requirements for treatment:

- Patients will be required to continue to see you for their medication management. We also strongly encourage patients to engage in regular therapy.
- All patients receiving SPRAVATO® treatment will be enrolled in a REMS monitoring program. We will assist with this enrollment process.
- Patients receiving SPRAVATO® will be required to remain in our office for 2 hours following treatment.
- Patients receiving IM ketamine will be required to remain in our office for 1 hour following treatment.
- Patients are not allowed to drive themselves to or from SPRAVATO® or ketamine treatment. They will need to have a driver for each scheduled treatment.

Please submit this completed form, along with any pertinent records, via fax to **970-591-9606**.

What you can expect after we receive this referral form:

- We will contact the patient within 3 business days of receipt of referral in order to schedule an intake appointment. During the intake appointment, we will collect other pertinent history, answer any patient questions, and discuss treatment options.
- If the patient has elected treatment with SPRAVATO®, we will gather and submit documentation for prior authorization.
- If the patient has elected treatment with SPRAVATO®, we will complete a benefits investigation and will notify the patient of any anticipated out-of-pocket costs.
- We will schedule the patient for treatment and notify you of the anticipated start date.
- We will update you regarding treatment response following initial treatment and we will maintain communication with you intermittently throughout course of treatment for your patient.

Referring Provider Signature: ______________________ Date: ______________