Massachusetts General Hospital
Founding Member, Mass General Brigham

Consultation Request/Referral Form for Ketamine Clinic

Please complete this form and email or fax to:
Email: mghketamineclinic@mgh.harvard.edu
Fax: 617-643-9048
You may call us with any questions or to follow up
Phone: 617-724-5510

Patient Name:

Patient Date of Birth:

Patient Phone Number:

Patient Email Address:

MGH Medical Record Number:
If patient does not have active MGH Medical Record Number, please call Patient Service Center at 866-211-6588

Referring Psychiatrist/Provider:

Other Providers Involved in Longitudinal Care:

Psychiatric Diagnoses:

Has the patient ever experienced psychotic symptoms? Y☐/N ☐
If Y, please provide more information:

Current Psychiatric and Medical Medications with Doses (Including All Supplements):

Past Psychiatric Medication Failures (include highest dose and duration):

Past Interventions (ECT, TMS, prior ketamine, esketamine):

Psychiatric History

Age of depression onset:

Length of current episode:

Hospitalizations:

Suicide History:

Self-Harm:

Medical History

Allergies:

Medical:

Surgical:

Anesthetic History:

Imaging Studies:

Substance History

NOTE: Patients with moderate-severe substance use disorders require at least 3 months of abstinence to be eligible for esketamine/ketamine

Alcohol:

Cannabis (including CBD, recreational or prescribed, please specify amount and frequency):

Other Illicit Drugs/Substances:

Tobacco/Nicotine vape:

Substance Use Treatment (Rehab/Detox):

Social History

Birth:

Education:

Marital Status:

Children:

Living Situation:

Employment:

Family History

Mood Disorders:

Alcohol abuse:

Substance abuse:

Suicides:

Other:

Clinician Contact Information

Office name:		
Phone Number:		
Fax #:		
Email Address:		
Clinician Name:	Clinician Signature:	Date: