

REFERRAL FORM: ESKETAMINE (SPRAVATO) TREATMENT

1. PATIENT DETAILS

NAME: DOB: PHONE: EMAIL: ADDRESS:

2. REFERRING PRACTITIONER DETAILS

NAME: PROVIDER #: PRACTICE: PHONE: FAX: EMAIL:

3. PBS ELIGIBILITY & CLINICAL INDICATION

MANDATORY CRITERIA FOR AUSTRALIA

☐ MDD Diagnosis☐ Treatment Resistant

DOCUMENTED FAILED TRIALS (DRUG / DOSE / DURATION):

4. FUNDING OPTIONS

☐ DVA

CARD NUMBER

☐ WorkCover

CLAIM NUMBER

☐ Private

(\$300 PER SESSION)

5. CONTRAINDICATIONS CHECK

*Please confirm the patient does **NOT** have:*☐ Aneurysmal vascular disease (including thoracic/abdominal aorta or intracranial vessels).☐ History of intracerebral hemorrhage.☐ Recent (within 6 weeks) myocardial infarction.SIGNATURE OF PRACTITIONER: DATE:

SUBMISSION INSTRUCTIONS

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