Depression MD
Dedicated to YOU

**Medical History**

Patient Name: _____ DOB: _____

Current Medical Diagnosis: _____

**Current and Past Medications Only: No Attachments Accepted. Fill form only.**

## NO MEDICATION RECONCILATION PRINTED NOTES WILL BE ACCEPTED

| **Medication & Dose**<br>*ex. Lipitor 20mg* | **Duration & Frequency**<br>*1 tab, once daily* | **Start Date**<br>*03/20/2021* | **End Date** | **What is/was this medication prescribed for?**<br>*Hypercholesterolemia* |
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**This patient is being evaluated for treatment with an antidepressant, Transcranial Magnetic Stimulation, Spravato (Esketamine) or Intravenous Ketamine. Please indicate if the patient was treated or is currently being treated for:**

| Medical Comorbidities | Yes | No |
|---|---|---|
| Allergies/hay fever | | |
| Angina | | |
| Asthma/ COPD | | |
| Cardiac pacemaker | | |
| Intracardiac lines/Supplemental O2 | | |
| Diabetes | | |
| Epilepsy | | |
| Fainting spells or syncope | | |
| Head Trauma/concussion with or without LOC | | |
| Heart attacks | | |
| Kidney stones or other renal problems | | |
| Hemodynamic Instability | | |
| Intracranial HTN/Bleed | | |
| Hepatic Disorders | | |

| Medical Comorbidities | Yes | No |
|---|---|---|
| Hypertension | | |
| Metal Implants | | |
| Migraines | | |
| MRI in the past | | |
| Seizures | | |
| Strokes/TIAs | | |
| Syncope | | |
| Thyroid | | |
| Hypersensitivity to Ketamine/Esketamine/Excipients | | |
| IV Ketamine/Spravato in the past | | |
| TMS in the past | | |
| AV malformations | | |
| Intrathoracic/abdominal aneurysms | | |
| Other | | |

**Please identify any other medical comorbidities:**

**Are there any medical contraindication to this patient for the following procedures (see below)?**

**Transcranial Magnetic Stimulation (TMS)**: [ ] Yes [ ] No

**IV Ketamine/Spravato :** [ ] Yes [ ] No

**If Yes, explain:**

**Ketamine and esketamine (Spravato) are contraindicated in patients with:**
Aneurysmal vascular disease (including thoracic and abdominal aorta, intracranial, and peripheral arterial vessels) or arteriovenous malformation. History of intracerebral hemorrhage. Hypersensitivity to esketamine, ketamine, or any of the excipients. Pregnancy. If the patient had intolerance please let us know what these are (eg nausea, disguesia, dissociation) please list these and we will address them with the patient.

**Transcranial Magnetic Stimulation are contraindicated in patients with:**
History of seizures. Ferromagnetic or magnetic sensitive metal objects implanted in the head or neck areas. Pacemakers, Vagus Nerve Stimulator, Cochlear implants, Pregnancy

_____ _____

**Medical Provider Name and Office (printed)** **Signature**:

_____ _____ _____

**Date** **Phone** **Email**

******Please send completed form records@depressionmd.com or our fax number is 877-325-2241******

Depression MD
Dedicated to YOU

**Psychiatric History**

Patient Name: _____ DOB: _____

Current Diagnosis: _____

Start Date of Current Depressive Episode: _____

**Current and Past Medications Only: No Attachments Accepted. Fill form only.**

## NO MEDICATION RECONCILATION PRINTED NOTES WILL BE ACCEPTED

| **Medication & Max Dose** *ex. Sertraline 20mg* | **Duration & Frequency** *1 tab, once daily* | **Start Date** *03/20/2021* | **End Date** *09/20/2021* | **Response** *AEs/ nonresponder/other:cost etc* |
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_____ _____

**Psychiatric Provider Name and Office (printed)** **Signature**:

_____ _____ _____

**Date** **Phone** **Email**

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## Psychotherapy History

**Kindly complete this form, in this format, in its entirety. This format is necessary for insurance prior authorization. Without this format, this request cannot be accepted. Reconciliation notes from EHRs are not acceptable for prior authorizations. Supplemental letters may also be submitted, however not as a replacement to this form and format.**

Patient Name: _____ DOB: _____

Current Diagnosis: _____ Start Date of Current Episode: _____

**Psychotherapy History:**

| **Type of Therapy** *ex. CBT* | **Duration & Frequency** *12 weeks, once weekly* | **Start Date** *03/20/2021* | **End Date** *09/20/2021* | **Rating Scale, Start/End Score** *Hamilton Depression Scale (30/12)* |
|---|---|---|---|---|
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**For any discontinued, not completed, therapy above, please explain the reason for discontinuation**

_____ _____

**Psychotherapy Provider Name and Office (printed)** **Signature**:

_____ _____ _____

**Date** **Phone** **Email**

******Please send completed form records@depressionmd.com or our fax number is 877-325-2241******