COASTAL
KETAMINE CLINIC

5675 Spring Garden Rd, Unit 6A
Halifax, NS B3J 1H1
Inside Springview Family Practice

Email: Contact@CoastalKetamine.ca
(Phone) 902-329-3016 **(Fax)** 902-417-1227

Ketamine Therapy Referral Form

Patient Information:

FIRST NAME | LAST NAME | DATE OF BIRTH (MM/DD/YYYY)

ADDRESS | CITY | PROVINCE | POSTAL CODE

EMAIL ADDRESS | PHONE NUMBER

HEALTH CARD NUMBER AND/OR VETERAN ID NUMBER | PATIENT NEXT OF KIN

Current Medications + Doses:

NONE: ☐

Previously Failed Medications or Therapies:

Past Medical History:

Indications For Ketamine Therapy:

*(Please check all that apply)

- ☐ Major Depressive Disorder
- ☐ Bipolar Depression
- ☐ Anxiety
- ☐ Post-Traumatic Stress Disorder
- ☐ Other: _____
- ☐ Obsessive-Compulsive Disorder
- ☐ Chronic Pain
- ☐ Substance Use Disorder

Potential Contraindications To Ketamine Therapy:

*(Please check all that apply)

- ☐ Dementia
- ☐ Unstable Medical Disorder
- ☐ Currently Pregnant or Breastfeeding
- ☐ Uncontrolled Hypertension
- ☐ Cerebral Aneurysm
- ☐ History of Psychosis
- ☐ History of Substance Dependence
- ☐ Current Illicit Substance Use
- ☐ Severe Personality Disorder
- ☐ Known Allergy to Ketamine

If you responded Yes to any of the above, please explain:

_____

_____

_____

Physician/Nurse Practitioner/Psychologist/Psychiatrist Information:

_____ _____

Name Signiture

_____ _____ _____

Date Phone Fax

Please Forward Completed Coastal Ketamine Clinic Referrals to:

Fax: (902) 417-1227
Email: contact@coastalketamine.ca