TORONTO KETAMINE CLINIC
123 Edward Street | Toronto, Ontario | M5G0A8
Call: 416.546.0675 | Email: info@torontoketamineclinic.com | FAX: 647.417.7153

Inclusion and Exclusion Criteria

Inclusion Criteria for IV Ketamine

● Adult patients 18 years of age and older.
● Patients with documented ***Treatment Resistant Depression"** as defined below, who have **current** moderate to severe depressive symptoms.
● The **current primary** diagnosis, as defined by the DSM-5, is Major Depressive Episode (MDD), or Bipolar 1 disorder or bipolar 2 disorder depressive phase. The patient may have another DSM-5 diagnosis, but this diagnosis **cannot** be the primary condition or focus of individuals who have suicidal ideation during the current episode of MDE and meet the above criteria.
● All patients must complete a medical form and be cleared for intravenous ketamine by the TKC anesthesiologist. The anesthesiologist will review the completed medical form prior to the first infusion and any identified medical concerns will be addressed. The patient may be declined from receiving ketamine treatment based on their medical history.
● All patients must have capacity to sign a written informed consent for treatment.
● Individuals Post Traumatic Stress Disorder (PTSD) or Obsessive-Compulsive Disorder (OCD) will be considered on a case-by-case basis.

Exclusion Criteria for IV Ketamine

● Patients with a primary diagnosis other than MDD or bipolar 1 or 2 diagnosis.
● Patients who are diagnosed with **psychosis,** even if it is a symptom of MDE.
● Patients with **neurocognitive disorders,** including dementias.
● Patients who have **traumatic brain injury** that is symptomatic.
● Patients who, within the previous three months, meet the DSM-5 criteria for **Alcohol Use Disorder**, or other **Substance Use Disorder**.
● Patients who do not meet the DSM-5 criteria for substance use disorder, but who use illicit substances, **must stop all illicit substances** for a minimum period of 1 month prior to the first infusion at TKC and remain free from substance use during the treatment time.
● Patients who are unable to provide a written informed consent for ketamine treatment.
● Patients who are not able to abide by the pre-treatment and post-treatment clinic protocol such as: food intake, abstaining from certain medications, unable to remain in the clinic post-treatment for a minimum of 20 minutes or longer for observation, those who insist on driving immediately post-treatment, and those who cannot provide the TKC with the name and phone number of the party who will pick them up post-treatment.
● Patients with uncontrolled hypertension, epilepsy, allergies to ketamine, a previous reaction to ketamine, Body Mass Index greater than 35, patients who are pregnant or planning to become pregnant within 12 weeks of treatment completion, hepatic impairment, history of recent heart attack, vascular disease, or any other medical conditions that may be deemed by the anesthetist as a contraindication to receiving ketamine.
● Individuals who are symptomatic for infection, or who have had contact with someone with an acute contagious illness.
● Individuals who are not Canadian residents or do not have a most responsible physician (MRP) in Canada.
● Individuals who demonstrate verbal, physical or emotional aggression toward TKC staff.

Treatment Resistant Depression (TRD)

Treatment Resistant Depression the patient has failed at least two guideline concordant trials of antidepressant therapy for major depressive disorder or bipolar depression, as recommended in either the CANMAT MDD Guidelines 2016, Florida Medicaid Guidelines 2019, or the CANMAT ISBD Guidelines for BD 2018.

Inclusion and Exclusion Criteria Agreement

(the following must be checked off by the MRP)

Place cursor in highlighted areas to either check boxes or enter text

	I confirm that the patient meets all of the above inclusion and exclusion criteria.
	I confirm that I am the patient's ongoing MRP. I will continue to be involved in the patient's care and provide ongoing psychiatric/mental health care before, during and after receiving treatment at TKC.
	I will review all notes and recommendations sent by the TKC for this patient.
	I understand that TKC is not able to provide ongoing psychiatric care.
	I will notify TKC if the patient develops new medical conditions, or undergoes new treatments, including medications, during the time the patient is receiving treatment at TKC.

Referral Request

Referring Physician Contact Information

Name:	
Clinic:	
Phone #:	
Fax #:	
Email Address:	
CPSO #:	
Billing #:	

Patient Information

Name of Patient:	
Patient Date of Birth:	
Patient OHIP #:	
Patient Email:	
Patient Phone #:	

What is your patient's Primary diagnosis (please choose one of the following):

- ◯ Major Depressive Disorder
- ◯ Bipolar 2 Disorder, DEPRESSIVE phase

What is your patient's Secondary diagnosis (please select all that apply)

- ☐ Cognitive impairments Please Specify:
- ☐ dissociative identity disorder
- ☐ Personality Disorders Please Specify:
- ☐ Schizophrenia or other Psychotic Disorders
- ☐ Bipolar I Disorder
- ☐ Alcohol Use Disorder or other Substance Use Disorder Name:
- ☐ Anxiety Disorders Please specify:
- ☐ Attention Deficit Hyperactivity Disorder
- ☐ No Secondary diagnosis

Please describe the patient's **Current Psychiatric** symptoms.

Medications and Treatments

(**Details MUST be provided or referral will be considered incomplete)**

	YES	NO
Has the patient had **2 trials of antidepressant medications** during the **CURRENT** episode of depression as defined by **Treatment Resistant Depression?**		
Has the patient had ECT (Electroconvulsive Therapy)?		
Has the patient had TMS (Transcranial Magnetic Stimulation)?		

Current Treatments and Psychiatric Medications- must provide details

Name of Medication or Treatment	Current Dose	Length of Time/Effectiveness
Eg. Pristiq	**150 mg po once daily**	**Started 1-2 years ago, increased to current dose 8 m ago. Helped 5-10%.**

Past Treatments and Psychiatric Medications- must provide details

Name of Medication or Treatment	Maximum Dose	Length of Time on Maximum Dose	Reason for Stopping or Side Effects
Eg. Lamotrigine	150mg PO Once Daily	6 months	dizziness

List Current Physical Medications

Name	Dose

Current Medical History **(** please provide details in space below)

- ☐ Cardiac/Cardiovascular disease
- ☐ Unstable or poorly controlled hypertension
- ☐ Uncontrolled brady or tachyarrhythmias
- ☐ Vertigo
- ☐ Respiratory
- ☐ Hepatic
- ☐ Pancreatic
- ☐ Genitourinary
- ☐ Renal
- ☐ Gastrointestinal
- ☐ Drug or alcohol dependence
- ☐ Allergies (environmental/medications)
- ☐ Ventricular shunts
- ☐ Uncontrolled hyperthyroidism
- ☐ None
- ☐ Other:

Past Medical History (please select all that apply)

- ☐ Cardiac/Cardiovascular disease
- ☐ Unstable or poorly controlled hypertension
- ☐ Uncontrolled brady or tachyarrhythmias
- ☐ Vertigo
- ☐ Respiratory
- ☐ Hepatic
- ☐ Pancreatic
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- ☐ Renal
- ☐ Gastrointestinal
- ☐ Drug or alcohol dependence
- ☐ Allergies (environmental/medications)
- ☐ Ventricular shunts
- ☐ Uncontrolled hyperthyroidism
- ☐ None
- ☐ Other:

Physician Signature: _____

Date: _____