BRAXIA HEALTH

PHYSICIAN REFERRAL FORM

PLEASE SELECT LOCATION OF REFERRAL

☐ BRAXIA MISSISSAUGA
1100 Dundas St.W., Unit #6
TEL: 416-430-9619
FAX: 1-877-919-0861

☐ BRAXIA OTTAWA
1081 Carling Ave., Suite 600
TEL: 416-430-9619
FAX: 1-877-919-0861

☐ BRAXIA MONTREAL
1140, Avenue Beaumont,
TEL: 514-481-7867
FAX: 1-877-919-0861

☐ BRAXIA KITCHENER
4278 King St. E.
TEL: 416-430-9619
FAX: 1-877-919-0861

Patient Information

First Name *	Last Name *		
Address			
Address 2			
City	Prov.	Postal Code	
Phone Number *	E-Mail Address *		
Date of Birth (DD/MM/YY) *	Health Card *		

Gender ☐ MALE ☐ FEMALE ☐ OTHER

Physician Information

Physician's First Name *	Physician's Last Name *		
Physician's Address			
Physician's Address 2			
Physician's City	Phys. Prov.	Phys. Postal Code	
Billing Number *	Physician's Phone Number*	Fax Number *	
Specialty *	Physician's E-Mail Address		

☐ FAMILY PHYSICIAN ☐ PSYCHIATRIST

Is the patient rostered into a group practice (FHO, FHT, etc) ☐ Yes ☐ No

Reason for Referral: You would like your patient to be considered for (Check all that apply):

☐ Ketamine ☐ rTMS ☐ Psilocybin

Patient's Primary Diagnosis? *

☐ Major Depression Disorder ☐ Bipolar Disorder ☐ Post Traumatic Stress Disorder ☐ Obsessive Compulsive Disorder ☐ Personality Disorder
☐ Other:

Patient's Secondary Diagnosis? *

☐ Major Depression Disorder ☐ Bipolar Disorder ☐ Post Traumatic Stress Disorder ☐ Obsessive Compulsive Disorder ☐ Personality Disorder
☐ Social Anxiety Disorder ☐ Generalized Anxiety Disorder ☐ Attention Deficit Hyperactivity Disorder
☐ None ☐ Other:

Please describe the patient's current symptoms. *

Please list any other current medical illnesses.

BRAXIA HEALTH

PHYSICIAN REFERRAL FORM
PAGE 2

Please list ALL medication that the patient is CURRENTLY taking and their dosages. *

Please select the medications that the patient may have tried at some point in the past.

☐ Agomelatine	☐ Cytomel (T3)	☐ Levomilnacipran	☐ Oral Ketamine	☐ Suboxone
☐ Amitriptyline	☐ Desipramine	☐ Lithium	☐ Paliperidone	☐ Tranylcypromine
☐ Aripiprazole	☐ Desvenlafaxine	☐ Lurasidone	☐ Paroxetine	☐ Trazodone
☐ Benzodiazepines	☐ Divalproex	☐ Mianserin	☐ Phenelzine	☐ Triiodothyronine
☐ Brexpiprazole	☐ Duloxetine	☐ Milnacipran	☐ Pregabalin	☐ Venlafaxine
☐ Bupropion	☐ Escitalopram	☐ Mirtazapine	☐ Quetiapine	☐ Vilazodone
☐ Buspar	☐ Fluoxetine	☐ Modafinil	☐ Reboxetine	☐ Vortioxetine
☐ Cannabis	☐ Fluvoxamine	☐ Monoclobemide	☐ Risperidone	☐ Vyvanse
☐ Carbamazepine	☐ Gabapentin	☐ Nasal Esketamine	☐ Selegiline transdermal	☐ Ziprasidone
☐ Caripiprazine	☐ IV Ketamine	☐ Nortriptyline	☐ Sertraline	
☐ Citalopram	☐ Lamotrigine	☐ Olanzapine	☐ Stimulants (e.g. methylphenidate, lisdexamfetamine, etc)	

Has your patient ever had electroconvulsive therapy (ECT)? *

☐ Yes ☐ No

Has your patient ever had transcranial magnetic stimulation (TMS)? *

☐ Yes ☐ No

Has your patient ever been prescribed Ketamine or Esketamine by a healthcare provider for a mental disorder (e.g., major depressive disorder)? *

☐ Yes ☐ No

Does your patient have a current/past history of alcohol use disorder or substance use disorder? *

☐ Yes ☐ No

Has this patient been seen by a psychiatrist at MDPU/UHN/TWH in the past year that recommended ketamine (e.g., Dr. Rosenblat or Dr. McIntyre)? Please send notes if applicable *

☐ Yes ☐ No ☐ Other

Is the patient receiving ongoing care from a psychiatrist? *

☐ Yes ☐ No ☐ Referring physician is a psychiatrist

PLEASE SEND ALL PERTINENT CLINICAL SUMMARIES/LAB TESTS/PHYSICAL EXAM FINDINGS

I confirm that I am the patient's MRP and will be involved in this patient's care, providing ongoing psychiatric care leading up to and after the patient receives treatment at the CRTCE. The CRTCE will monitor the patient's psychiatric state during treatment and will consult with me, the referring physician, should it be deemed necessary. I will review notes and recommendations sent by the CRTCE for this patient. I understand that CRTCE is not able to provide ongoing psychiatric care.

Additional Documents Attached ☐

Signature of Referring Physician

Date of Referral