MICHIGAN MEDICINE
UNIVERSITY OF MICHIGAN

Department of Psychiatry Clinical Intake Form
TMS/Ketamine

Both TMS and IV Ketamine are meant primarily for the treatment of Refractory Depression.

Patients must have had at least two antidepressants in the past year, and preferably a history of four failed trials at adequate dose and duration, including failure of combination antidepressants, to establish that they are "treatment-refractory".

Contraindications include: For TMS, history of any metal objects in the brain (e.g. wires or stents from cranial surgery), history of seizures, current significant substance use, or significant cognitive impairment. For Ketamine, unstable medical conditions including: hypertension, angina, severe respiratory illnesses, or anything that would be considered a risk for outpatient procedures. Chronic use of high doses of benzodiazepine also may impact response to Ketamine.

Send referral to: UMKetamine@med.umich.edu

PATIENT, REFERRING, AND ROUTING INFORMATION

PATIENT DEMOGRAPHICS

Name	DOB	Age	Sex	Preferred Phone Number ( ) -
Address	City		State	Zip Code
Primary Insurance	Pre-cert Req? ☐ Yes ☐ No	Subscriber Name		Sbscrb DOB / /
Contract #	Group #	UM MRN # (if known)		

REFERRING CLINICIAN

Name		Practice/Clinic	
Address		City	State / Zip Code
Preferred Phone Number ( ) -	Fax Number ( ) -	E-mail (if OK to use to communicate about referral)	

PATIENT HISTORY

Major Depression, Treatment Refractory ☐ Yes ☐ No	**PHQ9 Score (if known):**
History of Psychotherapy? ☐ Yes ☐ No	**Psychotherapy Dates:**

Psychiatric Diagnoses:	**Currently Active Medical Conditions/ Comorbidities:**

Current Meds as of _____ (date) and duration of each med treatment:	**History of Medications Used for Depression in Past Year:**				
	Med Name	**Max Dose Used**	**Duration**	**Response**	**Discontinued for side effects/ lack of efficacy?**
Med_____Duration_____				None ☐ Partial ☐ Transient ☐	
Med_____Duration_____				None ☐ Partial ☐ Transient ☐	
Med_____Duration_____				None ☐ Partial ☐ Transient ☐	
Med_____Duration_____				None ☐ Partial ☐ Transient ☐	

Provide a summary of previous Ketamine, TMS, or ECT treatments, if applicable. Please include dates and numbers of treatments, response, and/or complications.

History of Psychiatric Admissions, Suicide Attempts, Psychotic Episodes, and Substance Use Disorder: