UC DAVIS HEALTH | Advanced Psychiatric Therapeutics

Referral Form

Overview

- The Advanced Psychiatric Therapeutics clinic offers Transcranial Magnetic Stimulation (TMS) and SPRAVATO® intranasal esketamine treatment.

Eligibility

- Age ≥18
- Diagnosis of moderate to severe Major Depressive Disorder
- Patient is considered treatment-resistant[1]
- Referred by psychiatrist or Psychiatric Mental Health Nurse Practitioner who will continue management during and after the interventional treatment course.

Referral Process

- Please complete this form and fax to **916-551-2797.**
- If clinical and insurance eligibility criteria are met, your patient will be scheduled for an evaluation.
- If you have questions, please contact our team at 916-703-3300.

Treatment

- The clinic will manage your patient's course of TMS or SPRAVATO® treatment.
- The clinic does not provide medication management, psychotherapy, or longitudinal psychiatric care.
- Your patient will be instructed to contact you for medication management issues or psychiatric emergencies.
- For questions, please call **916-703-3300.**

Patient Name:		Date of Birth:
Patient Phone #:	Patient Email:	
Patient Address:		
City:		Zip:
Primary Insurance Name:		ID Number:
Secondary Insurance Name:		ID Number:

Patient is aware of and consents to this referral:	☐Yes	☐No
Patient consents to be contacted at the above phone number:	☐Yes	☐No

[1]Treatment-resistant depression (TRD) is defined as inadequate response or intolerance to 2 or more antidepressant medications, from different classes, in the current episode. Some insurance providers require a trial of evidence-based psychotherapy and/or augmentation with lithium, buspirone, or second generation antipsychotics before covering TMS or SPRAVATO® treatment.

Referral Form

Referring Provider Name:	
Provider Phone #:	Provider Fax #:

Current Psychiatrist *(if other than the referring provider):*	
Name:	Phone:

Current Therapist *(if other than the referring provider):*	
Name:	Phone:

Referral Diagnosis:	
Reason for Referral:	
PHQ-9:	Date:

Other Psychiatric Disorders:
Medical Diagnoses:
Current Medication List:

Please provide details of at least two antidepressant medication trials, from two different medication classes, in the current episode. Please be as detailed as possible, including information on effectiveness and tolerability.

Medication	Dose	Dates/Duration	Outcome

Referring Provider Signature: _____ Date: _____

Return by fax to 916-551-2797. For questions, call 916-703-3300

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