OZARK CENTER
An Affiliate of Freeman Health System
**PRISM Psychiatric Interventionist Services Referral Form**

PRISM, a service of Ozark Center, provides psychiatric interventionist services for those with severe or treatment resistant depression and/or other psychiatric disorders indicated below.

**What intervention are you referring to?**

❑ **Spravato (Esketamine)**: an NMDA receptor antagonist approved for Treatment Resistant Depression in adults.

❑ **Transcranial Magnetic Stimulation (TMS)**: indicated for treatment of depression in adults with Major Depressive Disorder who failed to achieve satisfactory improvement from previous antidepressant medication treatment. TMS is also indicated as an adjunct for treatment of adults with Obsessive-Compulsive Disorder (OCD).

❑ **Electroconvulsive Therapy (ECT)** is indicated for treatment of severe or treatment-resistant depression in adults that have persisted beyond an exhaustive continuum of treatment measures.

## Patient Information

**Name:** _____ **DOB:** _____

**Phone Number:** _____ **Email:** _____

**Diagnosis:** ❑ F32.2 Major Depressive Disorder, single episode, severe without psychotic features

❑ Treatment Resistance (failed **TWO** or more antidepressants)

❑ Major Depression with Suicidal Ideation

❑ F33.2 Major Depressive Disorder, recurrent without psychotic features

❑ F42.0 Obsessive-Compulsive Disorder

## Referring Provider Information

**Name:** _____ **Practice:** _____

**Phone:** _____ **Fax:** _____

Please identify each antidepressant the patient has failed, dates the patient took the antidepressant, dose, frequency, and reason for discontinuation. (**This information is needed for insurance authorization.)**

| Medication | Initiation/Stop Dates | Dosage | Frequency | Reason for Discontinuation |
|---|---|---|---|---|
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Please call the PRISM office (417) 347-7288 with any questions. Please fax completed form with records **including insurance information** to (417) 347-8099.

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- Has the patient ever lost consciousness without any known reason? ❑ YES ❑ NO
- Does the patient have a history of uncontrolled hypertension? ❑ YES ❑ NO
- Does patient have any type of cognitive impairment? ❑ YES ❑ NO
- Does patient have sensitivity to esketamine, ketamine, or excipients? ❑ YES ❑ NO ❑ Unknown
- Has the patient ever been diagnosed with bipolar mania? ❑ YES ❑ NO

  If yes, when was the last manic episode? _____

- Does the patient have a history of auditory/visual hallucinations or psychosis? ❑ YES ❑ NO

  If yes, please describe: _____

- Has the patient had evidence-based psychotherapy known to be effective in the treatment of Major Depressive Disorder (MDD) or Obsessive-Compulsive Disorder (OCD)? ❑ YES ❑ NO

  Dates of Therapy: _____ Doctor/Therapist: _____

  Duration/Outcome: _____

  Depression Rating Scales Used: _____ Model of therapy used: _____

  _____

- For TMS specifically: Does the patient have any of the following: metal plates/screws, pacemakers, permanent hearing aids, implantable or wearable cardiac defibrillators, vagus nerve stimulator, permanent makeup or tattoos with metal ink, bullet fragments, aneurysm clips/coils, cochlear implants, ferromagnetic implants in eyes or ears, deep brain stimulation devices, or any other type of implant or metal fragments? Specify below.

  _____

***After we receive your referral form, we will do the following:***

- We will contact your patient and schedule a screening appointment and discuss treatment, answer preliminary questions, and collect any other relevant information needed.
- We will gather and submit documentation for prior authorization with insurance
- We will complete a benefits investigation and notify the patient of any anticipated out-of-pocket costs.
- We will update you when your patient is scheduled with us and again following initial treatment to share information regarding treatment response.

**Signature: _____** **Date: _____**



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