Thank you for considering the Wayfound Ketamine Assisted Therapy program for your patient! To minimize the amount of stress placed on the client during this process and to ensure your referral is processed in a timely manner, please review the following information and let us know if you or your patient have any questions or concerns prior *to* referring.

Our highest obligation is always to the physical, emotional, and mental safety and wellbeing of our clients. As such, if a referral is incomplete or missing information it may be rejected. For this reason and to avoid any delays in your patient's treatment, please ensure that you fill out every field in your referral before submission.

Please note that the Wayfound Ketamine Program is **not eligible for coverage through provincial health care**. The only services covered by Alberta Health Care are those provided directly by a psychiatrist. This will include one of the client's initial assessments and any subsequent follow up appointments with the psychiatrist specifically.

Prior to referring, please ensure you have informed your patient of this and the following:

- The patient will be responsible for paying out-of-pocket for all appointment fees.
    - Integration sessions may be eligible for coverage by private insurance plans (please have your patient discuss this with their provider); however, the Wayfound Ketamine Program ***does not direct bill to any insurance providers***.
- Prescriptions for ketamine will be faxed from Wayfound directly to the pharmacy. The patient will be responsible for contacting the pharmacy and picking up their ketamine prior to dosing appointments, as well as all associated costs.
- If your patient has a third party claim they must advise their case manager of this referral request prior to any appointments being booked.
- Clients may request to have their integration therapy conducted by a psychologist not employed by Wayfound ***only if said psychologist has completed ATMA's KAT Clinician Training program***.

By signing below and submitting this referral I confirm that:

- The provider has reviewed and confirmed understanding of the information listed above with the patient and notified them of this referral
- The provider has provided the patient with a copy of the Wayfound KAT Program Summary (attached)
- The provider and patient understand that their referral may be rejected at the discretion of the Wayfound KAT Program if deemed ineligible or incomplete, and that the provider will be notified via fax should this occur

_____	_____	_____
Provider Name (please print)	*Provider Signature*	*Date*
_____	_____	_____
Patient Name (please print)	*Patient Signature*	*Date*

KETAMINE ASSISTED PSYCHOTHERAPY – INDIVIDUAL PROGRAM OVERVIEW

PHASE 1

1. **Referral**
   - All clients must be referred to Wayfound by a doctor or psychologist who has a Practice ID - this referral **must specify it is for the ketamine program**
2. **Forms**
   - Upon receipt of an eligible referral, clients will be emailed the following forms:
     i. Client Intake Form
     ii. Physician Assessment Form
   - Both forms must be completed in full and returned to reception@wayfound.ca before progressing to phase 2.

PHASE 2

3. **Assessments**
   - Upon receipt of completed forms, clients will be contacted to book the following:
     i. Initial psychiatric assessment (2hrs) [billed to AHS]
     ii. Initial intake assessment/prep session #1 (1hr) [$250]
   - After completing both assessments (if deemed eligible for treatment), the treating practitioners will create a treatment plan customized to the client's needs (please note this will not be ready until after the following Monday)
4. **Prep Therapy**
   - Clients will be contacted to book a minimum of 2 preparatory psychological sessions (including the assessment/prep session) to be completed before progressing to phase 3.
   - Clients are required to provide their credit card when booking
     i. Each Psychological Prep Session (1hr) [$250 – billed to client]
     ii. Some clients may require additional prep sessions – this is due only to the fact that every person's treatment needs are unique and does not bear any indication of their eligibility for the program

PHASE 3

5. **Micro Dose**
   - Clients who complete all required prep sessions and are deemed eligible for ketamine treatment will be contacted to book a one-off micro dosing appointment with a licensed Advanced Care Paramedic or Registered Nurse, followed by an integrative therapy session with a registered psychologist. The purpose of the Micro Dose is to ensure there are no allergies or adverse reactions to the ketamine
     i. Micro Dose (2hrs) [$285 – billed to client] ****ketamine not included****
     ii. Integration Therapy (1hr) [$250 – billed to client]
6. **Macro Dose**
   - Clients who have no adverse reactions to their micro dose will be emailed a dosing schedule according to their treatment plan (this may consist of 5-8 dosing sessions, each followed by an integrative therapy session)
     i. Macro Dose (2.5hrs) [$360 – billed to client] ****ketamine not included****
     ii. Integration Therapy (1.5hrs) [$375 – billed to client]

Cost Summary:

Phase 1 – $250
Phase 2 – $250 minimum
Phase 3 - $4210 - $5470 (not including cost of medication)

Program Total: $4,710 - $5,470

Wayfound

KETAMINE REFERRAL FORM

Patient Information

Last Name *(Legal)*:	First Name *(Legal)*:	
Preferred Name:	DOB *(mm/dd/yyyy)*:	
Alberta Health Care #:	VAC #:	WCB #:
Email:	Phone (1):	Phone (2):
Patient Address: *Unit/Street No. Street Name City Province Postal Code*		

Additional Patient Information

- ☐ Patient has a guardian
- ☐ Patient has an alternative contact
- ☐ Patient has vision requirements
- ☐ Patient has hearing requirements
- ☐ Patient has physical limitations
- ☐ Patient is unable to communicate in English

Referrer Information

Date of Referral *(mm/dd/yyyy)*:	
Referring Clinician:	PracID:
Clinic:	Phone:
Clinic Address:	Fax:
Family Physician *(If different from above)*:	PracID:
Clinic:	Phone:
Clinic Address:	Fax:

Referral Information

Is this referral in relation to an active WCB claim for this patient? ○ Yes ○ No

Priority of Referral	○ Routine	○ Urgent	○ Emergent
Patient's Current State	○ Stable	○ Worsening	

Active Medications	Active Medical/Psychological Conditions

Referral Details:

Completed By:

Name	Signature	Date