PHYSICIAN ASSESSMENT INTAKE

Dear Physician,

Your patient has been assessed and referred to our clinic for possible treatment with ketamine assisted psychotherapy (KAP), as they have attempted traditional methods of treatment for PTSD and treatment resistant depression to little or no effect. It is important to us that our patients' primary care physician is part of the treatment team as we believe the patient will have better outcomes with open communication between team members. In order for us to proceed, it is important to ensure that your patient is medically safe to take part. We ask that you review the following information and complete the attached assessment form.

KETAMINE ASSISTED PSYCHOTHERAPY

Ketamine assisted psychotherapy has shown through research to be a safe and effective option for treating a variety of mental health conditions. It is already being employed by the public health system to treat conditions such as pain management, anesthesia, and treatment resistant depression.

As with any medical or mental health treatment, patients will each have a different experience and outcome, however it is generally expected that low-dose psycholytic therapies (including KAP) may reduce ego defenses, promote insights and empathogen-like responses. Higher sub-anesthetic doses may create dissociative, psychedelic, out-of-body, and ego-dissolving peak responses.

PROGRAM DETAILS

Our Ketamine Assisted Psychotherapy (KAP) program is adjusted to suit the needs of each of our clients, therefore the frequency and duration of the treatment may vary.
The program includes:

- A 2-level assessment process conducted by a psychiatrist and registered psychologist
- Supervised oral or IM administration of ketamine by an advanced care paramedic
- Psychedelic-Assisted Psychotherapy sessions conducted by a registered psychologist with specialized training in this field

If you have any questions or concerns please contact us via email at reception@wayfound.ca and we will try to get back to you within 1-2 business days.

PHYSICIAN ASSESSMENT FORM			
Patient Information			
Last Name *(Legal)*:	First Name *(Legal)*:		
DOB *(mm/dd/yyyy)*:	PHN:	Gender:	
Email:	Phone (1):	Phone (2):	
Alternate Contact:	Phone (1):	Phone (2):	
Patient Address: *Unit/Street No. Street Name City Province Postal Code*			
Physician Information			
Referring Clinician:		PracID:	
Clinic:		Phone:	
Clinic Address:		Fax:	
Family Physician *(If different from above)*:		PracID:	
Clinic:		Phone:	
Clinic Address:		Fax:	

Physical Examination *(within 30 days of program start)*			
CNS			
CVS			
RESP			
Blood Pressure		Heart Rate	
Height		Weight	

Please prepare a requisition for the patient for the following:

- Urinalysis
- Blood work: CBC, creatinine, B12, B6, electrolytes, GGT, ALT, Random Glucose or HbA1c, hCG (women); Men over 50: Testosterone, TSH
- ECG

There are Contraindications to KAP treatment. Please indicate if any of these apply:

- ☐ Schizophrenia
- ☐ Bipolar Disorder
- ☐ Borderline Personality Disorder (unstable)
- ☐ Active psychotic disorder
- ☐ Active significant substance abuse (unable to detox)
- ☐ Pregnancy
- ☐ Uncontrolled severe hypertension
- ☐ Unstable Medical Condition (ie. Unstable CAD, uncontrolled Diabetes, uncontrolled seizure disorder, etc.)

If you have any questions, please don't hesitate to contact us.