POLARIS PSYCHIATRY

Dr. Christopher Hammel, MD, MPH, and Dr. Tonya Ruggieri, MD
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Privacy-Protected Phone: (860) 846-7137
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TMS Referral Form

TMS is a non-invasive, FDA-approved treatment for depression in patients who have not responded to two or more medication trials. It can also be used for OCD and smoking cessation.

Referral steps:

1. Please forward (1) this form, (2) your intake note, and (3) your last progress note to either fax: 860-590-3921 or our secure email: info@polarispsychiatry.com. We cannot proceed without all three as we will be unable to obtain insurance approval.
2. We will contact the patient directly to schedule, and we will manage all contact with insurance.

Patient's Name: _____ DOB: _____ Phone: _____
Insurer_____ ID #_____ Group #_____ Provider Phone:_____

The patient has failed at least two antidepressant medications. These medications are:

Medication	Maximum Dosage	Dates of Trial

Please provide the following contact information if applicable (required for certain insurers):

	Name	Phone Number
Prescriber:		
Current therapist:		
Past therapist:		

This section is only for primary care physicians.

Through my signature below, I certify that the patient is medically cleared for TMS, and that

- The patient does not have metallic objects or ferromagnetic medical implants (including certain hearing implants) in their head or neck (dental fillings are safe).
- The patient does not have a known seizure disorder.
- The patient has not been diagnosed with bipolar disorder, schizoaffective disorder, or schizophrenia, as TMS can worsen mania, paranoia, delusions, and hallucinations.

_____ _____ _____
MD Signature Date Time

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Esketamine (Spravato) Referral Form

Esketamine (Spravato) is an FDA-approved nasal spray which works rapidly to relieve symptoms of depression in patients who have not responded to two or more antidepressant medications.

Please forward (1) this signed form, (2) your intake note, and (3) your last progress note to either Fax: 860-590-3921 or our secure Email: info@polarispsychiatry.com. We cannot obtain insurance approval without all three documents. We will manage all patient and insurance contact directly.

Patient's Name: _____ DOB: _____ Phone: _____
Insurer_____ ID #_____ Group #_____ Provider Phone:_____

*The patient has failed at least two antidepressant medications, and is **currently** taking one, as follows:*

Medication	Maximum Dosage	Start Date	Stop Date
			[CURRENT ANTIDEP.]

Please provide the following contact information if applicable (required for certain insurers):

	Name	Start/End Dates/Frequency	Phone Number
Prescriber:			
Current or past therapist:			

To the best of my knowledge at the time of this referral, the patient has no known history of the following: psychosis, active substance use disorder, aneurysmal vascular disease, arteriovenous malformation, intracerebral hemorrhage, hepatic impairment, hypersensitivity to ketamine or esketamine.

I understand that Polaris Psychiatry exclusively provides esketamine services, and **not** ongoing psychiatric care, medication management, or medication refills. Further, while patients will be screened for safety concerns, suicidal ideation and other issues that may arise **must** be managed by their referring physician.

_____ _____ _____ _____
Prescriber Signature | Prescriber Printed Name | Date | Time