# MEDICAL CLEARANCE REQUEST

**Spravato® (Esketamine) and/or Transcranial Magnetic Stimulation (TMS)**

| SENT FROM (Requesting Practice) | SENT TO (Primary Care Provider) |
|---|---|
| **Practice/Clinic name:** | **PCP/Practice name:** |
| **Provider:** | **Attn:** |
| **Phone:** | **Phone:** |
| **Fax:** | **Fax:** |

**Date of Request:** _____

## PATIENT INFORMATION

**Patient Name:** _____

**Date of Birth:** _____

## PURPOSE OF REQUEST

Our office is evaluating the above patient for treatment with Spravato (esketamine) and/or Transcranial Magnetic Stimulation (TMS) for treatment-resistant depression. As part of our standard intake process, we are requesting your assistance as the patient's primary care provider in completing the medical clearance screen below, based on your knowledge of the patient's medical history.

**We are requesting clearance for:**

☐ Spravato (Esketamine)

☐ Transcranial Magnetic Stimulation (TMS)

☐ Both

## SPRAVATO (ESKETAMINE) CONTRAINDICATION SCREEN

*Please indicate whether the patient has any history of the following:*

| Question | Yes | No |
|---|---|---|
| Aneurysmal vascular disease or AV malformation | ☐ | ☐ |
| History of intracerebral hemorrhage | ☐ | ☐ |
| Known hypersensitivity to esketamine or ketamine | ☐ | ☐ |
| Uncontrolled hypertension | ☐ | ☐ |

## TMS CONTRAINDICATION SCREEN

*Please indicate whether the patient has any history of the following:*

| Question | Yes | No |
|---|---|---|
| Metal implants or other ferromagnetic material in or near the head | ☐ | ☐ |
| History of seizure disorder or increased seizure risk | ☐ | ☐ |
| Recent or progressive neurological changes | ☐ | ☐ |
| ETOH | ☐ | ☐ |

**If yes to any item above, please describe:**

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## CLEARANCE DETERMINATION

☐ Patient is cleared for Spravato (esketamine) treatment.

☐ Patient is NOT cleared for Spravato (esketamine) treatment.

☐ Patient is cleared for TMS treatment.

☐ Patient is NOT cleared for TMS treatment.

**Additional Comments:**

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**PCP Signature:** _____

**Printed Name:** _____

**Date:** _____

*Please fax this completed form back to the number listed above. Thank you for your assistance in coordinating this patient's care. If you have any questions, please contact our office.*