

Thank you for contacting the Brain Research and Interventional Neurotherapeutics (BRaIN) Program at Butler Hospital. Our clinical service offers a suite of interventional psychiatry services aimed at supporting your patients when first-line approaches may not be successful. Insurance company policies for these treatments have various eligibility requirements for coverage. We must collect and review detailed information about a patient's medical history and past treatment history to determine their eligibility and medical appropriateness.

am referring my patient for:
TMS Therapy
Esketamine (Spravato)
Outpatient Electroconvulsive Therapy (ECT)
PRISM Therapy
I'd like the Butler provider to evaluate my patient and recommend which treatment might be best
Transcranial Magnetic Stimulation (TMS)
Inclusion: Primary Diagnosis of MDD; moderate to severe, without psychotic features covered by all insurance companies for adults and adolescents (15 YO and older) or OCD for select insurers
Exclusion: Non-removal metal in head (except dental), epilepsy, seizure disorder, severe brain injury/

## **Esketamine (Spravato)**

trauma, stroke, brain tumor

Inclusion: Primary Diagnosis of MDD; moderate to severe, without psychotic features

Exclusion: Aneurysmal vascular disease, active substance use disorder

(unless in remission > one month), uncontrolled hypertension

## **PRISM Therapy**

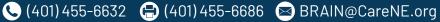
Inclusion: Diagnosis of PTSD (available on a self-pay basis only) or Clinical Research Trial for MDD with Anhedonia

## **Outpatient Electroconvulsive Therapy (ECT)**

Inclusion: MDD, Bipolar Disorder, Schizophrenia/Schizoaffective, Catatonia, Psychotic Depression Exclusion: Unstable cardiac disease, uncontrolled hypertension, pregnant, obesity with concurrent medical issues









INSTRUCTIONS: Please complete this form and fax it, together with a copy of the patient's most recent office visit note, to (401) 455-6686. If you have any questions, our clinic staff can be reached at (401) 455-6632 or by email at BRAIN@CareNE.org. REFERRING PROVIDER: Name:\_\_\_\_\_\_ Agency:\_\_\_\_\_ Phone:\_\_\_\_\_\_ Fax:\_\_\_\_\_ CURRENT OUTPATIENT PROVIDER (if different than above): PATIENT INFORMATION: Name:\_\_\_\_\_ Date of Birth:\_\_\_\_\_ Phone: Primary Psychiatric Diagnosis:\_\_\_\_\_\_ Additional Diagnoses:\_\_\_\_\_ **MEDICATION TREATMENT HISTORY:** Please include all medication trials for MDD, including augmenting agents **Outcome/Side Effects** Medication Max Dose Start Date End Date TREATMENT HISTORY: ☐ Yes ☐ No Psychotherapy? Name/Dates: ☐ Yes ☐ No TBI or seizures? Describe: **Substance Use Disorder?** Yes  $\square$  No Current Status:\_\_\_\_\_ ☐ Yes l No Past TMS? When/Outcome?\_\_\_\_\_  $\square$  No Yes Past ECT? When/Outcome?\_\_\_\_\_  $\square$  No | Yes Past Ketamine? When/Outcome? No When/Outcome? ADDITIONAL NOTES/RELEVANT CLINICAL INFORMATION: