BUTLER HOSPITAL

BRAIN RESEARCH AND INTERVENTIONAL NEUROTHERAPEUTICS (BRaIN) PROGRAM

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.

I 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/ trauma, stroke, brain tumor

Esketamine (Spravato)

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

Brain Research and Interventional Neurotherapeutic (BRAIN) Program

345 Blackstone Blvd., Providence, RI 02906

(401) 455-6632 (401) 455-6686 BRAIN@CareNE.org

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

Medication	Max Dose	Start Date	End Date	Outcome/Side Effects

TREATMENT HISTORY:

Psychotherapy? ☐ Yes ☐ No Name/Dates:_____

TBI or seizures? ☐ Yes ☐ No Describe:_____

Substance Use Disorder? ☐ Yes ☐ No Current Status:_____

Past TMS? ☐ Yes ☐ No When/Outcome?_____

Past ECT? ☐ Yes ☐ No When/Outcome?_____

Past Ketamine? ☐ Yes ☐ No When/Outcome?_____

Past Esketamine? ☐ Yes ☐ No When/Outcome?_____

ADDITIONAL NOTES/RELEVANT CLINICAL INFORMATION:

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