Qi Integrated Health

Ketamine-Assisted Therapy at Qi Integrated Health

Qi Integrated Health is proud to be offering Ketamine Assisted Therapy (KAT) to support people who desire to improve their quality of life by improving their mental health.

Medical evidence demonstrates that KAT can be an effective option for people struggling with depression, grief, anxiety, loss, or seeking healing from past trauma. It has even proven to be an innovative alternative for those with treatment-resistant conditions who have tried medications and non-medicated psychotherapy with little success.

Our group and personalized, 1-on-1 programs at Qi are safe, monitored, therapeutic treatment trajectories overseen by clinical doctors, nurses, and counsellors, with years of combined psychedelic experience and training.

If you have patients or connections you believe could benefit from exploring KAT, we would be honoured to talk with them about the healing potential of Ketamine-Assisted Therapy at Qi.

Referrals can be done directly using this form or alternatively your patients can book a complimentary consultation at www.qiintegratedhealth.com/ketamine-assisted-therapy

About Qi

Qi Integrated Health is Vancouver's largest integrated health clinic. We apply an allied approach to healthcare, resulting in a unique, nurturing and personalized healing experience. As our name implies, we are the life force behind delivering the highest level of patient care to our customers in an innovative, world-class facility to assist our patients in living a more vibrant and meaningful life. For more information, please visit us at www.qiintegratedhealth.com

REFERRAL FOR KETAMINE-ASSISTED THERAPY TREATMENT

1. Patient Information

FIRST AND LAST NAME
HEALTH CARD# (include version code) or M / R / UCI#
INSURANCE POLICY NUMBERS (if applicable)
INSURANCE CARRIER:
VETERAN ID (if applicable)
DATE OF BIRTH (YYYY/MM/DD)
GENDER

ADDRESS
CITY / PROVINCE / POSTAL CODE
PATIENT CARETAKER (if applicable)
TELEPHONE (home): ____________________ (mobile):_____________________ Can a voicemail be left at this number for an appointment: Yes ❏ | No ❏
EMAIL ADDRESS

2. Exclusion Criteria

Absolute Contraindications:

- ☐ Pregnancy
- ☐ Allergy to Ketamine
- ☐ Active psychotic symptoms
- ☐ Dementia of delirium
- ☐ Extreme emotional instability

Relative Contraindications:

- ☐ Uncontrolled hypertension above 140/90
- ☐ Severe liver disease
- ☐ Severe kidney disease
- ☐ Severe cardiac or vascular disease

3. Health Information

MENTAL HEALTH CHALLENGES (check all that apply):

- ☐ Treatment Resistant Depression
- ☐ Generalized Anxiety Disorder
- ☐ PTSD
- ☐ Grief
- ☐ Substance Use Challenge (please list substance(s)): ____________________________________
- ☐ Disordered Eating

- [ ] Adjustment Disorder
- [ ] Suicidal Ideation
- [ ] Chronic Pain
- [ ] Sleep disorders
- [ ] Other: ____

ANY INPATIENT MENTAL HEALTH ADMISSIONS (And approximate dates):

Any history of self-harm behaviour (please specify):

Psychotherapy/counseling/therapy:

Mental Health medications used:

Substance Use History:

Family history of mental health challenges:

Please check all current medications & specify which:

- [ ] Benzodiazepines _______________________________
- [ ] Dextromethorphan_______________________________
- [ ] Lamotrigine _______________________________
- [ ] Buprenorphine _______________________________
- [ ] Psychostimulants (including ADD/ADHD meds):_______________________________
- [ ] MOAIs (Phenelzine, Selegiline) _______________________________
- [ ] Midodrine _______________________________
- [ ] Antidepressants _______________________________
- [ ] Calcineurin inhibitors (cyclosporine, tacrolimus)_______________________________
- [ ] Corticosteroids_______________________________

- ☐ Estrogens___________________________
- ☐ NSAIDS___________________________
- ☐ Testosterone___________________________
- ☐ Triptans___________________________
- ☐ Other (please list all other medications:____________________

Any Abnormal ECGs or Lab results:

Accessibility:

- ☐ Ambulatory Aids: ______________________
- ☐ Ostomy Bag: _________________
- ☐ Disabilities ___________________
- ☐ Other: _____________________

4. Mandatory Vitals

Date Vitals Taken: ________________

- ☐ BP_____________
- ☐ HR____________
- ☐ RR____________
- ☐ Weight (kg please):_________

5. Referring Physician Information

FIRST AND LAST NAME
BILLING #
ADDRESS
CITY / PROVINCE / POSTAL CODE
TELEPHONE
FAX
PHYSICIAN SIGNATURE

6. Fax/Submit

Please send this form with any relevant recent investigation and consultation reports and we will contact your patient directly to schedule an appointment. We will also follow up by providing you with a detailed consultation report.

Fax to 604-742-8382 OR Mail to Qi Integrated Health. 1764 West 7th Ave, Vancouver, BC, V6J 5A3

Important: A consultation appointment can only be scheduled once ALL the requested documentation has been received and reviewed.