# Ketamine Intervention Program at SGH
# Information & Client Referral

**OVERVIEW**

The Ketamine Intervention Program (KIP) is a pilot program at Squamish General Hospital (SGH) funded by Vancouver Coastal Health (VCH). The KIP-SGH is offering intravenous (IV) or subcutaneous (SUBCUT) racemic ketamine treatment for eligible outpatients with treatment-resistant depression (TRD). The treatments are given twice a week for up to 3 weeks (up to 6 treatments), with case-by-case limited follow up treatments every 4-8 weeks for up to 6 months. The KIP is not able to provide maintenance treatments beyond 6 months.

During each treatment session at SGH, clients will be seen by the psychiatrist and staff where they will receive IV/SUBCUT ketamine followed by monitoring (blood pressure, adverse events) for up to 2 hours until ready for discharge. Clients should be accompanied by a responsible adult and should not drive following a treatment session. The client will remain under the care of the referring physician during and following ketamine treatment.

Generally, concurrent antidepressants and other psychotropic medications can be continued during ketamine treatment. However, if current medications are not beneficial before ketamine, they're unlikely to be helpful to prevent relapse after ketamine. Expert consensus recommends starting a new antidepressant or adjunctive medication when initiating (or shortly after) acute ketamine treatment.

**TO REFER**

Please complete the KIP Referral Form and the checklist below. A psychiatrist will assess the client and confirm eligibility.

**ELIGIBILITY CHECKLIST**

To confirm client eligibility, and before enrolment, the referring physician should **complete this checklist and send this with the client referral information**:

- ☐ Resident of VCH region
- ☐ Age 18 years or older.
- ☐ Primary diagnosis of major depressive episode (major depressive disorder [MDD] or bipolar disorder [BD]).
- ☐ If MDD, failed adequate trials of failed adequate trials of greater than or equal to 2 antidepressants AND greater than or equal to 1 adjunctive treatment(s). If BD, failed adequate trials of greater than or equal to 3 agents (lithium, lamotrigine, quetiapine, lurasidone, adjunctive SSRI/bupropion).

- ☐ Normal physical examination (please include the results of the physical exam if available).
- ☐ No unstable medical conditions, such as cardiovascular or respiratory disease.
- ☐ No poorly controlled hypertension.
- ☐ If indicated by history and/or physical examination: bloodwork (CBC, TSH, liver function, etc.), urine drug screen, electrocardiogram (ECG) (please include the latest results if available).

- ☐ No active psychosis
- ☐ No alcohol or substance use disorder within past 6 months.
- ☐ Not pregnant or breastfeeding.
- ☐ No contraindications as per the product monograph: aneurysmal vascular disease or arteriovenous malformation, intracerebral haemorrhage, and hypersensitivity to ketamine or esketamine.

For any questions, please contact KIP-SGH, **778-894-3200** for administration or clinical issues.

# Ketamine Intervention Program – Squamish General Hospital (KIP-SGH) Referral

**Client Information: (Please complete if no addressograph)**

- Full Name: _____
- PHN: _____ DOB: _____
- Home Address: _____
- City/Town: _____ Postal Code: _____
  Home Phone: _____ Cell Phone/Email: _____

**Demographics:**

This pilot program is committed to ensuring the inclusion of Indigenous, Black, and People of Colour in accessing ketamine intervention. When clients self-identify, they are helping us to ensure equitable access for racialized, marginalized, and intentionally excluded underserved populations.

- Sex: M / F / Other Pronoun: _____
- Age: _____
- Race/Ethnicity: _____
- Do you identify as Indigenous (that is, First Nations, Inuit, and/or Métis)? □ Y / □ N
- Primary Language: _____
- Interpreter required: Y / N

**Referral Contact Information:**

Referral Psychiatrist: _____ MSP: _____
Referral Psychiatrist Clinic Name & Address: _____
_____
Referral Psychiatrist Phone: _____ FAX: _____

**Other Support Information:**

KIP wants to ensure that there is ongoing support for all our clients. By providing the following information, this will help our team know that current supports are in place.

Primary Care Provider (e.g, Physician, Nurse Practitioner) : _____
Primary Care Physician Phone: _____
Mental Health Therapist, and/or Counsellor, and/or Elder or Knowledge Keeper/Carrier: _____
MH Therapist Phone: _____
Other: _____

**Current Therapeutic Involvement (check all that apply):**

□ Psychiatrist □ Therapist
□ GP □ MH Team
Which Team & case manager name if not listed: _____
□ Other: _____

**Rationale:**

Diagnosis & Reason for ketamine trial: _____
_____

**Treatment refractory criteria**: Clients with major depressive disorder who have failed adequate trials of greater than or equal to 2 antidepressants (e.g. SSRI, SNRI, bupropion, mirtazapine, tricyclics) AND greater than or equal to 1 adjunctive treatment(s) (e.g. 2nd generation antipsychotic, lithium, thyroid hormone, psychostimulants)

**OR**

Clients with bipolar disorder, depressed, who have failed adequate trials of greater than or equal to 3 agents (lithium, lamotrigine, quetiapine, lurasidone, adjunctive SSRI/bupropion).

Please list antidepressants tried to date of adequate dose & duration:

_____

AND at least one adjunctive medication (list all):

_____

Medications that were not beneficial before ketamine treatment are unlikely to be helpful to prevent relapse after ketamine treatment. **New antidepressant or adjunctive medication when initiating (or shortly after) acute ketamine treatment is recommended.**

Medication change(s) being considered around time of ketamine treatment?

_____

_____

**Baseline Physical Health Assessment (within the last 30 days).**

Please attach the following:

- □ Physical examination, including weight and body mass index
- □ Blood work: CBC, electrolytes, liver function tests, renal function tests, TSH and pregnancy test as appropriate
- □ Electrocardiogram (ECG)

**Collateral Information:**

- □ Attach most recent psychiatric consultation and progress notes.
- □ Medical Diagnoses: _____
  _____
- □ History & Date of previous ECT, TMS, or (es)ketamine: _____
  _____
- □ List of current medication(s) or attach MAR:
  _____
  _____
  _____
  _____

Referring Physician Signature: _____ Date: _____

**FAX the completed referral to Ketamine Intervention Team [604-815-4197] to arrange consultation.**