Tri-MED
INTEGRATIVE PSYCHIATRY & SLEEP MEDICINE
Maximal Health, Minimal Medicine

PATIENT NAME:_____DOB:_____PHONE#:_____
ADDRESS:_____
INSURANCE:_____ ID#:_____
PHARMACY:_____ PHONE#:_____
REFERRAL SOURCE:_____ PHONE#:_____
CURRENT PSYCHIATRIC PROVIDER/FACILITY:_____

EMERGENCY CONTACT INFORMATION:

NAME:_____ PHONE#_____ CAN WE LEAVE MESSAGE: **Y N**

RELATIONSHIP TO PATIENT:_____

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION/ MEDICAL RELEASE:

NAME /ORGANIZATION/ PHYSICIAN:_____ PHONE#_____

[ ] RELEASE ALL HEALTH INFORMATION **[ ]** RELEASE ALL BILLING INFORMATION

[ ] DO NOT RELEASE ANY INFORMATION OR SPEAK TO ANYONE **[ ]** RELEASE ALL INFO TO MY EMERGENCY CONTACT

Are you currently or have you been diagnosed with any of the following in your past? C= CURRENT P=PAST

- Major Depressive Disorder: C / P Date:
- Suicidal Ideation*: C / P Date:
- Bipolar Depression: C / P Date:
- Postpartum Depression: C / P Date:
- Generalized Anxiety Disorder: C / P Date:
- Obsessive Compulsive Disorder: C / P Date:
- Post-Traumatic Stress Disorder: C / P Date:
- Other:

Please list current or past medications, doses, and frequency taken:

MEDICATION	DOSE (MG.)	FREQUENCY	PAST / PRESENT
1			
2			
3			
4			
5			

Do you have any **Drug allergies?** If yes, please also list your reaction:_____
_____
Have you had any seizures in the past? _____
Have you experienced a poor response to oral antidepressants in the past?_____
Have you experienced intolerable side effects to antidepressants in the past?_____
Have you failed treatment with: ECT / TMS / Psychotherapy?_____
Have you participated in: Inpatient Psychiatric Hospital or Intensive Outpatient Program?_____
Are you currently pregnant, breastfeeding or planning to become pregnant in the next 6 months?_____

I certify that the information provided above is complete and accurate to the best of my knowledge.

_____ _____
PATIENT SIGNATURE **DATE**

Tri-MED
Please continue to complete each field below

SYSTEMS REVIEW	In the past month, have you had any of the following problems?	
GENERAL	**THROAT**	**SKIN**
❑ Recent weight gain; how much	❑ Frequent sore throats	❑ Redness
❑ Recent weight loss: how much	❑ Hoarseness	❑ Rash
❑ Fatigue	❑ Difficulty in swallowing	❑ Nodules/bumps
❑ Weakness	❑ Pain in jaw	❑ Hair loss
❑ Fever	**NERVOUS SYSTEM**	❑ Color changes of hands or feet
❑ Night sweats	❑ Headaches	**BLOOD**
MUSCLE/JOINTS/BONES	❑ Dizziness	❑ Anemia
❑ Numbness	❑ Fainting or loss of consciousness	❑ Clots
❑ Joint pain	❑ Numbness or tingling	
❑ Muscle weakness	❑ Memory loss	**PSYCHIATRIC**
❑ Joint swelling	**STOMACH AND INTESTINES**	❑ Depression
Where?	❑ Nausea	❑ Excessive worries
EARS	❑ Heartburn	❑ Difficulty falling/staying asleep
❑ Ringing in ears	❑ Stomach pain	❑ Poor appetite
❑ Loss of hearing	❑ Vomiting	❑ Frequent crying
EYES	❑ Yellow jaundice	❑ Sensitivity
❑ Pain	❑ Increasing constipation	❑ Thoughts of suicide / attempts
❑ Redness	❑ Persistent diarrhea	❑ Stress
❑ Loss of vision	❑ Blood in stools	❑ Irritability
❑ Double or blurred vision	❑ Black stools	❑ Poor concentration
❑ Dryness	**KIDNEY/URINE/BLADDER**	❑ Racing thoughts
HEART AND LUNGS	❑ Frequent or painful urination	❑ Hallucinations
❑ Chest pain	❑ Blood in urine	❑ Rapid speech
❑ Palpitations	**Women Only:**	❑ Guilty thoughts
❑ Shortness of breath	❑ Abnormal Pap smear	❑ Paranoia
❑ Fainting	❑ Irregular periods	❑ Mood swings
❑ Swollen legs or feet	❑ Bleeding between periods	❑ Anxiety
❑ Cough	❑ PMS	❑ Risky behavior

Have you ever been diagnosed or treated for the following?

Uncontrolled hypertension? [ ] NO [ ] YES ONSET:_____
Unstable heart disease? [ ] NO [ ] YES ONSET:_____
Stroke or brain bleed? [ ] NO [ ] YES ONSET:_____
Aneurysm? [ ] NO [ ] YES ONSET:_____
Arteriovenous Malformation? [ ] NO [ ] YES ONSET:_____
Moderate to severe liver disease? [ ] NO [ ] YES ONSET:_____
Moderate to severe kidney disease? [ ] NO [ ] YES ONSET:_____
Psychosis? [ ] NO [ ] YES ONSET:_____
Schizophrenia? [ ] NO [ ] YES ONSET:_____
Bipolar Mania? [ ] NO [ ] YES ONSET:_____
A reaction to ketamine or esketamine? [ ] NO [ ] YES ONSET:_____
Do you have a diagnosis of Substance Use Disorder? [ ] NO [ ] YES ONSET:_____ Sobriety Date:_____

Have you ever used any of the following substances in the last 6 months? If yes, please list how often you have used them, the last date of use and if prescribed.

Marijuana: 0 No 0 Yes Frequency: _____ Last Used:_____ Prescribed? 0 No 0 Yes
Opiates: 0 No 0 Yes Frequency: _____ Last Used:_____ Prescribed? 0 No 0 Yes
Ketamine: 0 No 0 Yes Frequency: _____ Last Used:_____ Prescribed? 0 No 0 Yes
Cocaine: 0 No 0 Yes Frequency: _____ Last Used:_____
Alcohol: 0 No 0 Yes Frequency: _____ Last Used:_____
Tobacco: 0 No 0 Yes Frequency: _____ Last Used:_____
Vape: 0 No 0 Yes Frequency: _____ Last Used:_____
Phencyclidine (PCP): 0 No 0 Yes Frequency: _____ Last Used:_____
Lysergic Acid Diethylamide (LSD): 0 No 0 Yes Frequency: _____ Last Used:_____
Psilocybin (magic mushrooms): 0 No 0 Yes Frequency: _____ Last Used:_____

Current substance abuse or dependency can complicate treatment with Spravato and Ketamine. A history of substance abuse increases the risk of abusing ketamine recreationally. The following questions help us determine if treatment is appropriate for you.

Have you ever used drugs other than those required for medical reasons?	0 No 0 Yes
Have you ever abused prescription drugs?	0 No 0 Yes
Are you always able to stop drinking/ using drugs when you want to?	0 No 0 Yes
Have you ever been in trouble because of alcohol/ drug abuse?	0 No 0 Yes
Have you ever experienced withdrawal symptoms as a result of alcohol/ drug use?	0 No 0 Yes

PHQ9:

Over the last TWO WEEKS, how often have you been bothered by any of the following problems *use the scale provided to answer each question*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself- or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Thought that you would be better off dead, or of hurting yourself	0	1	2	3
9. Moving or speaking so slow that other people could have noticed. Or the opposite- being so fidgety or restless that you have been moving around a lot more that usual	0	1	2	3
	↓	↓	↓	↓
ADD COLUMNS:				

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	◯Not difficult at all ◯Somewhat difficult ◯Very difficult ◯Extremely difficult

Would you prefer treatment with: Ketamine Infusion / Spravato Nasal Spray / Undecided? (Please Circle One)

If approved for treatment, are you able to attend treatment appointments, consisting of: *twice a week for the first 4 weeks and weekly to monthly after?*	**0** No **0** Yes
Do you have reliable transportation (a driver) for treatment?	**0** No **0** Yes
Do you agree to not drive yourself to and from the office during treatment days?	**0** No **0** Yes
Do you understand that you may be released from care if you drive yourself on treatment days?	**0** No **0** Yes
Have you been made aware of and do you understand the side effects that may occur with treatment?	**0** No **0** Yes

C/ONSENT TO TREATMENT: I hereby give Dr. 'Yemi Aina and/or his associates' permission to examine me and treat me according to the diagnosis and treatment plan as explained to me in order to improve my medical condition. I hereby authorize payment directly to Tri-MED Behavioral & Sleep medicine, Dr. Oluyemi Aina and/or his associates for medical services provided to me.

Patient Name (Please Print):_____ Date:_____

_____
Signature of Patient or Guardian

Office Policies, Consent to appointment delays, Agreement for controlled substances, Consent to urine drug screens, and detailed Medical Release explanations can all be found under the section titled: ***CONSENT FORMS.*** By signing below, you acknowledge that you have read, downloaded a copy, and agree to comply to the terms that are thoroughly explained in the above-mentioned section. (A printed copy of the consents is available in office, upon your request)

Patient Name (Please Print):_____ Date:_____

_____
Signature of Patient or Guardian

PLEASE CONTINUE TO THE LAST PAGE TO COMPLETE THE JANSSEN BENEFIT INVESTIGATION FORM

Janssen
CarePath

I understand that my Protected Health Information will not be used or disclosed by Janssen CarePath for any other purpose without my prior authorization unless permitted by law or unless information that specifically identifies me is removed. I understand that Janssen CarePath will make every effort to keep my information private. I understand that if my information is accidentally shared, federal privacy laws do not require that the person/party receiving it will not disdose the information further and that such information provided to a third party may no longer be protected by federal privacy laws.

I understand that I am not required to sign this HIPAA Patient Authorization Form. My choice about whether to sign will not change the way my Healthcare Providers or Payer treat me. If I refuse to sign the HIPAA Patient Authorization Form, or cancel or revoke my authorization later, I understand that this means I will not be able to participate or receive assistance from Janssen CarePath.

1. I understand that I am entitled to a signed copy of this authorization.
2. I understand that this authorization shall expire either when I stop receiving Janssen CarePath resources or 10 years from the date of this authorization, whichever occurs first.
3. I understand that I may cancel or revoke this authorization at any time by notifying Janssen CarePath in writing at Janssen CarePath, P.O. Box13135, La Jolla, CA92037. I understand this will not affect information used and disclosed prior to receipt of my cancellation or revocation.
4. I understand that I have the right to review my health information that has been disclosed upon written request to Janssen CarePath, P.O. Box 13135, La Jolla, CA. 9203Z

Redisdosure: I understand that my Protected Health Information may be redisdosed by Janssen CarePath, for the purposes outlined above—to my health plan(s) or other third-party payer(s), my healthcare providers, and any individual I designate as a caregiver—and I specifically authorize such redisclosures.

[ ] I would like to receive information and updates about SPRAVATO" (esketamine) Nasal Spray CIII.

Patient name_____ Date of birth (mm/dd/yyyy) _____

Patient address _____

City _____ State____ ZIP _____

Patient email _____

Patient Signature _____ Date_____

If the patient cannot sign, patient's legally authorized representative must sign below:

By_____ Date _____
(Signature of person legally authorized to sign for patent)
Describe relationship to patient and authority to make medical decisions for patient: _____

Please call Janssen CarePath at 844-777-2828 or follow up with your doctor if you have questions about Janssen CarePath or this authorization.

Please read the full Prescribing Information, including Boxed WARNINGS and Medication Guide for SPRAVATO™ and discuss any questions you have with your doctor.