Behavioral Health Department
Alameda County Health

**Karyn Tribble, PsyD, LCSW**
*Director*

**Interventional Psychiatry Referral Form**

This is the first step in the referral process and not a guarantee for services. Once a referral is submitted, Bay Psychiatric Associates (BPA) will complete an independent assessment, and ACBHD Utilization Management (UM) will review for authorization.

**Please send completed form to: Florence Yuen, Interventional Psychiatry Administrative Supervisor**
p: (510) 843-2220 x156 ~ f: (415) 454-8591 **Email: Florence@baypsychiatric.com**

**Checklist Purpose:** The intention of this form is to guide providers on the minimum requirements for treatment eligibility. A Treatment Summary and Most Recent Progress notes may be provided in lieu of this form so long as the requirements are met.

**Prior Treatment Requirements:** TMS, Ketamine & Esketamine all require two failed complete six week trials of *appropriate* medications in two different classes. If there are "medication intolerances" included in the failed trials, then three trials are required. Trials must be verified by records or clinical documentation, or in below provider statement.

Name:
DOB:
Patients Phone:
Email address:
Mailing address:
Insurance ID #:

Please check which treatment modality for which you are making a referral:
☐Transcranial Magnetic Stimulation (TMS)
☐Electroconvulsive Therapy (ECT)
☐Esketamine/Ketamine

Referring provider name:
Referring provider phone:
Referring provider email:

Patient Diagnosis:

Current Medication(s):

Current Treatment Modalities (e.g. Individual and group therapy, med management, frequency of visits):

Current or Past Psychotherapy (frequency, length, results): *Prior engagement with psychotherapy is requested in good faith and not a hard requirement prior to receiving services. If there are barriers that prevent engagement in psychotherapy, please describe instead:

Hospitalization history (include date and location of last hospitalization):

Suicide History:

**For TMS:**

Patient Diagnosis (checkmark one):

☐ F33.0 Major Depressive Disorder, Recurrent, Mild

☐ F33.1 Major Depressive Disorder, Recurrent, Moderate

☐ F33.2 Major Depressive Disorder, Recurrent, Severe without Psychotic features

☐ F42 Obsessive Compulsive Disorder

* Must be one of these dx (or co-occurring with one of these dx)

Number of Psychiatric Medications Tried-Include Name, Doses and Trial Length:

| Medication – Antidepressants | Maximum dose | Start Date and End Date (month/year) | Outcome, side-effects, adherence, other relevant info |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

☐ Yes ☐ No History of seizures
☐ Yes ☐ No Metal in or around head
☐ Yes ☐ No History of or Current Psychosis
* Psychosis is contraindicated and excluded from this modality
☐ Yes ☐ No History of or Current Substance Use
*Recent or untreated substance abuse is excluded from TMS

**For Esketamine/Ketamine:**

Patient Diagnosis (checkmark one):

☐ F33.0 Major Depressive Disorder, Recurrent, Mild

☐ F33.1 Major Depressive Disorder, Recurrent, Moderate

☐ F33.2 Major Depressive Disorder, Recurrent, Severe without Psychotic features

* Must be one of these dx (or co-occurring with one of these dx)

Number of Psychiatric Medications Tried-Include Name, Doses and Trial Length:

| Medication – Antidepressants | Maximum dose | Start Date and End Date (month/year) | Outcome, side-effects, adherence, other relevant info |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Current or Past Psychotherapy:

Surgical History:

☐ Yes ☐ No Access to Accompanied Transportation Twice per Week
☐ Yes ☐ No History or Current Psychosis

* Psychosis is contraindicated and excluded from this modality

☐ Yes ☐ No History of or Current Substance Use
*Recent or untreated substance abuse is contraindicated/excluded from TMS

☐ Yes ☐ No Pregnant
☐ Yes ☐ No History of Cystitis/Urological Illness
☐ Yes ☐ No High Blood Pressure or Hypertension
☐ Yes ☐ No Cardiac Problems
☐ Yes ☐ No Respiratory Problems
☐ Yes ☐ No Liver or Kidney Problems
☐ Yes ☐ No Problems with Anesthesia

**For ECT**:
Patient Diagnosis:

☐ Yes ☐ No Recent Stroke or Myocardial Infarction
☐ Yes ☐ No Cochlear Implants
☐ Yes ☐ No Access to Accompanied Transportation Three Times Per Week (Rideshare not allowed)

Once the referral is submitted to BPA, they will reach out to schedule a time to meet for assessment and complete the section below to submit to ACBHD Utilization Management (UM) for authorization review.

**For BPA Use Only:**
Authorization Request is for:

☐ Ketamine infusion (IV) with monitoring initial:
first 3 weeks: 6 visits 1 session per day up to 2x/week CPT codes: 99214, 90833, 96365, J3490

☐ Ketamine infusion (IV) with monitoring continuation:
1 per week for 12 weeks CPT codes: 99214, 90833, 96365, J3490

☐ Ketamine injection (IM) with monitoring initial:
first 3 weeks: 6 visits 1 session per day up to 2x/week, CPT codes: 99214, 90833, J3490

☐ Ketamine injection (IM) with monitoring continuation:
1 per week for 12 weeks, CPT codes: 99214, 90833, J3490

☐ Spravato with monitoring initial: first 4 weeks: 8 visits, 1 session per day, 2x/week
CPT codes: Bundled: G2082 for a 56 mg treatment or G2083 for an 84 mg treatment
Or Unbundled: J0013 x mg, 99215, 99417 x 4

☐ Spravato with monitoring continuation: 1x/week for 12 weeks for maintenance
CPT codes: Bundled: G2082 for a 56 mg treatment or G2083 for an 84 mg treatment
Or Unbundled: J0013 x mg, 99215, 99417 x 4

☐ TMS initial: 36 visits - 1 session per day up to 5x/week
Codes: 90867 x 1, 90868 x 33, 90869 x2

☐ TMS maintenance: ___ visits - 1 session per day up to 5x/week
CPT Codes: TMS treatment 90868 x ___, TMS calibration 90869 x___ (if needed)
* BPA doctor may recommend and request more, for example if patient is a late responder to tx and would benefit from, or if they try a new protocol