



Dear Doctor,

Mindspace is a mental health company providing mental health services, including, where regulations allow, certain psychedelic-assisted psychotherapies. At Mindspace, we currently offer ketamine-assisted psychotherapy for depression, using sub-anesthetic non-parenteral ketamine in combination with an evidence-informed psychotherapeutic protocol over a treatment period of 4 weeks. We also offer individual psychotherapy (private pay or 3rd party insurance). Group programming is planned for launch in fall 2021 or winter 2022, potentially including a Group Medical Visit (GMV) series that delivers lifestyle, mindfulness and trauma-informed psychoeducation programming to patients who suffer from a diverse range of mental health conditions to help empower them to make evidence-informed lifestyle changes and become more engaged in their recovery.

Your patient is interested in being seen by an allied Mindspace physician for a screening assessment to determine if ketamine-assisted psychotherapy may be an appropriate treatment for their mental health needs. Their medical screening consultation is insured under RAMQ. The ketamine assisted psychotherapy protocol is currently an uninsured, private-pay treatment only.

While both medical and psychological considerations are considered at screening, we focus primarily on your patient's mental health concerns. Please ensure that all other medical conditions remain under your care (or other relevant specialists) and are optimally treated.

This referral will include an initial telehealth screening assessment, with additional assessment by a consulting psychiatrist as needed. Subsequently, the patient will be evaluated with an in-person visit including a physical examination. We will send a consult letter at the conclusion of the full assessment.

Please complete the attached form, and also provide the additional medical information requested including recent (past 3 months) liver enzymes and thyroid function results.

Feel free to contact me by phone, fax, or email if you wish to discuss this referral, treatment plan, or any concerns you may have.

Sincerely,

Dr. Joe Flanders, Psychologist (OPQ #11368-09)
Mindspace Clinical Lead

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PATIENT REFERRAL FORM

An electronic version of this form can be requested via email to info@mindspacewellbeing.com

PHYSICIAN INFORMATION

Referring Physician:		Phone:	Fax:
RAMQ Billing #:	Address:		
Family Physician:		Phone:	Fax:

PATIENT INFORMATION

Last Name:	First:	Middle:	
DOB:	RAMQ:		
Gender Assigned at Birth:		Preferred Gender:	
Address:	City:	Province:	Postal Code:
Cell Phone: (required)	Alternate Phone:	Email (required):	

PRIMARY INDICATION FOR REFERRAL FOR KETAMINE ASSISTED PSYCHOTHERAPY

<input type="checkbox"/> Treatment-resistant depression. <input type="checkbox"/> Other: _____

DOES YOUR PATIENT HAVE ANY OF THE FOLLOWING CONTRAINDICATIONS?

<input type="checkbox"/> Active liver disease (severe) <input type="checkbox"/> Cardiovascular disease <input type="checkbox"/> Cerebrovascular disease <input type="checkbox"/> Uncontrolled hypertension	<input type="checkbox"/> History of psychosis <input type="checkbox"/> History of mania / bipolar <input type="checkbox"/> Borderline personality disorder <input type="checkbox"/> active or chronic suicidality and self injury. <input type="checkbox"/> Seizure disorders	<input type="checkbox"/> Pregnancy* <input type="checkbox"/> Breastfeeding <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Acute Angle Glaucoma <input type="checkbox"/> Uncontrolled thyroid disorder
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*women of childbearing age must be on contraception if sexually active

Unfortunately, we are NOT able to accept a patient who: <ul style="list-style-type: none"> <input type="checkbox"/> Is not fluent in English or French <input type="checkbox"/> Has an active CNESST claim unless authorized <input type="checkbox"/> Is a non-Canadian resident

THERAPY SOUGHT

<input type="checkbox"/> Ketamine Assisted Psychotherapy
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PRIMARY MODALITY

Private Pay

- Ketamine-assisted psychotherapy for depression
- Non-psychedelic individual psychotherapy

COST

- Medical suitability screening assessments and follow-up are covered under provincial health care.
- Ketamine Assisted Psychotherapy is currently not medically insured service, thus the remainder of the program for those deemed eligible is private pay.
- Third-party insurance may apply on a case-by-case basis.
- The protocol includes three ketamine administration sessions spaced weekly in a specialized medically monitored setting with intensive psychotherapy provided before, during and after ketamine administration sessions.
- **Total Cost of program: \$4950**, of which \$3750 is psychological services delivered by a licensed psychologist, some portion of which may be covered by group insurance plans (patient is responsible for determining coverage and submitting claims).

MUST ATTACH

<input type="checkbox"/> Relevant past psychiatric evaluations	<input type="checkbox"/> Past medical history summary <input type="checkbox"/> Current/active issues list	<input type="checkbox"/> Medication list (DSQ) <input type="checkbox"/> ECG, TSH, AST/ALT* (within 90 days)
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CLINICALLY RELEVANT MEDICATION/TREATMENT (C=Current or P=Past) or attach Pharmanet profile

<input type="checkbox"/> SSRI C/P	<input type="checkbox"/> Benzodiazepine C/P	<input type="checkbox"/> Alpha/Beta Blockers C/P
<input type="checkbox"/> SNRI C/P	<input type="checkbox"/> TCA C/P	<input type="checkbox"/> Methadone/Suboxone C/P
<input type="checkbox"/> NDRI C/P	<input type="checkbox"/> Atypical Antipsychotics C/P	<input type="checkbox"/> ECT C/P
<input type="checkbox"/> MAOI C/P	<input type="checkbox"/> Cannabis/Cannabinoids C/P	<input type="checkbox"/> Other: _____

I confirm ALL of the following (please check ALL boxes)

<input type="checkbox"/> I am a family doctor (or psychiatrist) with a longitudinal relationship with this patient.	<input type="checkbox"/> I ensure that all other medical conditions remain under my care (or other specialists) and are stable.	<input type="checkbox"/> I have reviewed the above contraindications and can confirm my client does not have any contraindications.
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Physician Signature: _____ RAMQ #: _____ Date: _____

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PHYSICIAN CHECKLIST

Please attach,

- This referral form completed and signed.
- Patient's past medical history
- Past psychiatric or mental health evaluations
- DSQ medication history
- Lab Reports within past 90 days
 - ECG
 - TSH (Thyroid Function)
 - AST/ALT (Liver Function)

Please fax the referral form with attached information to:

MindSpace

Address:

393 av Laurier O, Montreal, QC H2V 2K3

Phone: (514) 481-0317

Fax: 1 (844) 927-4791

For more information on ketamine assisted psychotherapy, and other services offered at MindSpace, please visit our website at www.mindspacewellbeing.com in the Clinic and Psychedelics sections.

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