Roots to Thrive (Experiential Training) Intake Packet

Roots to Thrive Society for Psychedelic Therapy

Thank you for your interest in participating in Roots to Thrive (RTT) Experiencing Training.

Included in this packet are the following documents:

1. RTT Payment Policy
2. RTT Onboarding Agreements
3. RTT Physician referral form (requires primary care provider's signature)
4. RTT Consent form (for your review, signature not required yet)

Please follow the instructions below to process your paperwork. All steps must be completed in the following order to begin your intake process:

1. Register your interest in **RTT** via our online portal at https://oab.owlpractice.ca/rootstothrive
2. Review the **RTT** onboarding agreements (page 4). *Signature will be requested via Owl forms.
3. Complete the referral form with your physician. *Signature by primary care provider required.

Fax to Roots to Thrive at 250-244-8426 or email to navigator@rootstothrive.com

If you have any questions, please email navigator@rootstothrive.com or Julia@rootstothrive.com

Roots to Thrive Payment Policy

Payments:

As a non-profit society, Roots to Thrive relies on extensive volunteer hours and participant program fees to keep our program operational. We must financially break even, or we cannot continue to offer our programming thus, we thank you for your participation. Further, it is important that payments are received timely for the viability of the program.

The cost of our intake process is $500 and serves as a deposit for participation. Prior to your first intake appointment, this $500 non-refundable deposit is required. Should our Intake Team determine that the program is not a good fit for you at this time, your $500 deposit will be refunded. The Intake Team will provide recommendations for next steps to support your program readiness for future cohorts.

The balance of your invoice is due by the program start date. Additional payments may be made toward your balance any time between your initial intake, and the program start date, to allow for spacing of your payments if necessary. Full payments must be received by the start date, or participation will not be permitted.

Payment Options:

1. **E-Transfer (preferred):** Please send e-transfers to finance@rootstothrive.com.
2. **Credit Card:** If you require a payment via credit card, this can be done by emailing finance@rootstothrive.com to request a credit card invoice.
3. **Cheque:** Please make cheques payable to 'Roots to Thrive Society for Psychedelic Therapy' and mailed to **PO Box #41007, RPO Woodgrove, Nanaimo, BC V9T 6M7**

Feel free to email us with any questions.

Refund Policy:

Refunds are reviewed on an individual basis.

Refund requested before two weeks before the scheduled Experiential Training Intensive: Full refund, minus the $500 deposit.

No refunds are given after the start of the Experiential Training Intensive.

Roots to Thrive Experiential Training – Onboarding Agreements

Welcome to the Roots to Thrive Community! Below you will find information on the steps involved in our intake process.

INTAKE PROCESS:

All participants in RTT are required to be medically cleared by our intake team in order to participate. This process involves up to two intake appointments with our intake team.
All intake appointments are virtual and conducted within the Owl online portal.

CORE INTENTIONS OF RTT:

- To co-create a community that models unconditional positive regard for ourselves and for each other.
- To practice expressing ourselves authentically.
- To gently step beyond our comfort zones.
- To care for and support others.

INTAKE PROCESS AND COMMUNITY OF PRACTICE AGREEMENTS:

- I agree to pay the required deposit **prior** to my initial intake appointment.
- I agree to be on time for my intake appointments.
- I agree that if I need to change any of my intake appointments, I will give more than 24 hours' notice.
- I acknowledge that I am available for a 72-hour intensive experiential training, and have booked off the specified times in my calendar.
- I acknowledge that Experiential Intensive dates and times may changes and, in this event, the RTT Team will provide as much notice as possible.
- I acknowledge that I have read and agree to the payment policy.

These agreements will be sent to you for signature from the Owl online portal.

Physician Referral Form

To Whom It May Concern:

Please accept this request from your patient to participate in the Roots to Thrive with Ketamine Assisted Therapy program.

Traditional treatment modalities addressing PTSD, depression, and other treatment resistant mental health conditions have not been as successful as hoped in many people. Ketamine Assisted Therapy (KAT) is a safe and research-informed treatment option that shows promise in effectively treating a variety of mental health conditions. Ketamine is already used within health care to treat a variety of ailments, including pain management, anesthesia and treatment resistant depression.

Furthermore, based on our experience treating healthcare providers, the program has seen exceptional results treating symptoms related to PTSD, acute stress, unresolved grief, and adjustment disorder – all of which are becoming common challenges in today's healthcare environment.

Each patient experience will be different, but it is generally thought that low dose psycholytic therapies, such as KAT, reduce ego defenses, promote insights and empathogen-like (heart-opening) responses, while higher (but still sub-anesthetic) doses create dissociative, psychedelic, out-of-body, ego-dissolving peak responses. The RTT-KAT medical protocol uses intramuscular injection (IM), given in the shoulder or hip, delivering a highly bioavailable dose of medication, with a rapid onset.

The following article, Published in Frontiers of Psychiatry Journal, provides further information on program design and outcomes to date: https://www.frontiersin.org/articles/10.3389/fpsyt.2021.803279/full?utm_source=F-NTF&utm_medium=EMLX&utm_campaign=PRD_FEOPS_20170000_ARTICLE

Program information: Over 20 medical professionals are collaborating to run this program. It includes:

- Comprehensive medical and psychological intake assessment overseen by our lead psychiatrist.
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- Community of Practice meetings, 2-hours in duration, that offer resiliency knowledge, skills, and practice in a supportive community. It is not group therapy.
- One to Three Ketamine Assisted Therapy session (5 hours each) administered at Snuneymuxw Hulit Lelum (Health Centre) in Nanaimo.

PLEASE NOTE: If the patient has a mental health diagnosis, refer based on that diagnosis (if it aligns with the eligibility criteria as listed below). If the patient has not been assigned a diagnosis, please describe the patient's specific challenge(s), which will then be assessed by our intake team prior to entering the program.
If you have any questions, please email us at julia@rootstothrive.com with 3 specific days and times you are available for one of our clinicians to follow up. We will email you in response to let you know which day and time.
When the Referral form below is completed, please fax to 250-244-8426 (confidential) or email to navigator@rootstothrive.com INCOMPLETE REFERRALS WILL BE DECLINED.

Name: _____Gender: ☐ Male ☐ Female ☐ Non-binary
Surname First name

Address: _____
Street City Postal Code

DOB: _____ PHN: _____
(MM/DD/YYYY)

Preferred Phone: _____ Email: _____
Alternate Contact: _____ Phone: _____
Health Care Provider (HCP): _____ Phone: _____
Referring HCP: _____ Phone: _____ Fax: _____

HCP Signature: _____ HCP's Billing #: _____Date: _____

Exclusion Criteria:

- ☐ Presence of active psychotic symptoms
- ☐ Diagnosis of dementia or delirium
- ☐ Inability to tolerate group work
- ☐ Extreme emotional instability
- ☐ Ketamine Allergy
- ☐ Currently Pregnant
- ☐ Vascular Ehlers Danlos

Provisional Diagnoses: past and present (mark all that apply)

- ☐ Treatment Resistant Depression
- ☐ Obsessive Compulsive Disorder
- ☐ Post-Traumatic Stress Disorder
- ☐ Generalized Anxiety Disorder
- ☐ Adjustment Disorder
- ☐ Substance Use Disorder

AND/OR

Concurrent Challenges (separate from a formal/ongoing mental health diagnosis)

- ☐ Unresolved Grief
- ☐ Suicidal Ideation
- ☐ Sleep Disorders
- ☐ Chronic Pain
- ☐ Acute Stress

☐ History of Psychiatric in-patient admissions (please specify with dates):
_____

☐ Current or recent out-patient psychiatric care (please specify):
_____

☐ Any history of self-harm behavior (please specify):
_____

☐ Other: _____

Treatments tried (psychotherapy, therapy and pharmaceutical) for mental health condition with dates:

_____

_____

Personal Mental Health/Substance Use History:

_____

_____

Family Mental Health and Substance Use History:

_____

Allergies: _____

Does your patient have any of the following:

- Uncontrolled Hypertension
- Hepatic Disorders
- Kidney Disorders
- Recent cardiac disorders (i.e. myocardial infarction) within the last 12 months
- Vascular Disorders

Current Medications (noted but not limited to):

- Benzodiazepines: _____
- Lamotrigine
- Psychostimulants (including ADHD medications): _____
- MAOIs (Phenelzine, Selegiline): _____
- Antidepressants (venlafaxine, bupropion, desipramine): _____
- Calcineurin inhibitors (cyclosporine, tacrolimus): _____
- Corticosteroids: _____
- Estrogens: _____
- Midodrine
- NSAIDS (ASA, ibuprofen, naproxen, diclofenac, celecoxib, etc): _____
- Testosterone: _____
- Triptans: _____
- Other **(please list all other medications):**

  _____

  _____

Relevant Abnormal Lab/ECG Results: _____

Any accessibility or physical challenges?

- Ambulatory aids
- Ostomy Bags
- Disabilities

- Other (please specify):

_____

Baseline Vitals/Weight (MANDATORY)

Date:_____ BP:_____ Respiratory Rate: _____ Pulse:_____ Weight (kg please): _____

Is there any reason at all present or past that this patient could not sustain a 4-5 hours of increased blood pressure? This is an expected effect of ketamine.

- ☐ Yes
- ☐ No

Please explain: _____

The Roots to Thrive program is not a substitute for ongoing medical care. This will remain with the referring provider.

Name: _____
Designation: _____
Signature: _____
Date: _____