PROVIDER REFERRAL FORM

Infuzed Ketamine & IV Therapy accepts patients age 18 and older with major depression, persistent depressive disorder, seasonal affective disorder, postpartum depression, premenstrual dysphoric disorder, and atypical depression, along with bipolar disorder, chronic anxiety, PTSD, OCD, panic disorder, and agoraphobia.

PATIENT INFORMATION

NAME OF PATIENT _____

DATE OF BIRTH _____ EMAIL _____

CELL PHONE _____ ALTERNATE PHONE _____

DIAGNOSIS (Check All That Apply)

___ MAJOR DEPRESSIVE DISORDER ___ BIPOLAR DISORDER ___ PANIC DISORDER

___POSTPARTUM DEPRESSION ___ ANXIETY ___ PTSD ___OCD

___ OTHER: _____

REFERRING PROVIDER INFORMATION

Please include pertinent patient medical records. Patients with hypertension or over age 65 require cardiac clearance for ketamine therapy. We look forward to collaborating with you on your patient's treatment plan.

REFERRING PROVIDER NAME/DEGREE _____

PHONE _____ FAX _____ SPECIALTY _____

This patient and I would like to initiate ketamine infusions at INFUZED KETAMINE & IV THERAPY. I have examined this patient and certify that to the best of my knowledge, there is not a medical contraindication for undergoing Ketamine Infusion Therapy. If special instructions are required, I have indicated those clearly above.

PROVIDER SIGNATURE_____ DATE _____