Provider Referral for Ketamine Infusion Therapy

Medical or Mental Health Provider: ____

Address: ____

Phone: _______________ Fax: _______________ E-mail: ___________________________________

I am currently treating (patient name): ____,

For (list conditions & diagnosis)____

____

I feel that Ketamine infusion therapy may benefit this patient and am referring him/her for evaluation as an adjunctive treatment for his/her diagnosis. I agree to collaborate with my patient's Ketamine provider regarding the treatment of my patient.

I acknowledge that I may contact my patient's provider to discuss the treatment protocol and may review more information about this therapeutic option at iFusiondallas.com.

I will continue to follow and direct the care of my patient during and after the completion of the course of therapy and if applicable, will coordinate his/her care with his/her primary care or psychiatric physician or mental health nurse practitioner.

Provider Signature and Date: ____

Printed name: ____

This form must be returned by fax or email to iFusion Wellness and Ketamine Clinic.

Fax: (972) 863-7997

E-mail: Todd@ifusionallas.com