Ketamend of Michigan, PLLC

36400 Woodward Ave, Suite 110

Bloomfield Hills, MI 48304

248-617-6755

Provider Referral for Ketamine Injection/Infusion Treatment

I am currently treating (patient name):

_____

for (list conditions & diagnosis):

_____

_____

_____

I feel that ketamine therapy may benefit this patient and am referring for an 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 Ketamend of Michigan to discuss the treatment protocol at info@ketamendofmi.com or 248-617-6755. I will continue to follow and direct the care of my patient during and after the completion of the course of treatment and, if applicable, will coordinate his/her care with his/her primary care or psychiatric physician.

Provider Signature: **Date:**

_____

Printed Name:

_____

Referring Provider's Phone Number and/or Email:

_____

This form is confidential and may be emailed to *info@ketamendofmi.com*.