The Minnesota Ketamine & Wellness Institute

Confidential Provider Referral Form

I am currently treating (patient name): ____

Date of Birth: _____________ Patient contact phone number: ____________________

For the following diagnosis/conditions: ____

____

____

I believe that ketamine infusion therapy may benefit this patient and am referring him/her for ketamine infusion therapy. I acknowledge and agree to collaborate with MKW Institute regarding the treatment of my patient.

I defer decisions on specific treatment dosing to MKW Institute's Infusion Protocol, as established by MKW Institute. I acknowledge that I can contact my patient's provider to further discuss the treatment protocol and may further review information about this therapeutic option at MKW-Institue.com.   I will continue to follow and direct the care of my patient throughout this course of therapy or collaborate his/her care with a primary provider or mental health provider.

____ ____________________

Referring Provider Signature   Date

____ ____________________

Printed Name and Clinic Name   Phone number

Fax or email completed form to 763-432-5721 or info@mkw-institute.com
This form must be returned directly through the office of the referring provider. It cannot be submitted by the referred patient.