ADVANCED INFUSION & WELLNESS CENTER LLC

PROVIDER REFERRAL REQUEST FORM

REFERRING TO

Specialty: Ketamine Therapy	**Phone:** 877-393-AIWC (2492)	**Fax:** (316) 854-5194
Practice Name & Address: 10333 E 21st N Suite 106 Wichita KS 67220		

Please Schedule (select all that apply):

☐ Urgent-- Referring provider called _____

☐ Routine Appointment with Specific Provider listed:_____

☐ First Available with any Provider

Referring Provider's Name:	**Phone:**	**Fax:**

TYPE OF REFERRAL

☐ Evaluation consultation with treatment recommendations that primary care provider will continue to follow

☐ Evaluation consultation with assumed care for this condition.

☐ Evaluation consultation with treatment recommendations and shared care.

☐ Specialist to Specialist*–Secondary Referral
*Send copy of this referral to patient's primary care provider.

☐ Other (designate)_____

PATIENT INFORMATION

Patient Full Legal Name:		DOB
If patient is under 18 years old – Parent Contact Name:		
Preferred Phone:	Best time to call:	
Special Patient Considerations:		
Patient Insurance Information:		
Patient's Primary Care Provider:	Phone:	Email:

GENERAL INFORMATION

Reason for Referral (*Clinical Question*):

Comments/Considerations Related to Clinical Question: **Please include recent labs, pertinent imaging reports, medication list, problem list, allergies, and relevant clinical notes.**

Patient aware of reason for referral? ☐ Yes ☐ No: Explain

PROVIDER REFERRAL CONFIRMATION

REFERRAL CONFIRMATION

Referral Accepted? ☐ Yes ☐ No: Explain

Appointment Scheduled with:	**Date & Time:**

☐ Patient refused scheduling ☐ Patient prefers to contact specialist to schedule at a later date

Request for additional supporting clinical information (please detail):

Person completing confirmation:	**Date of Confirmation:**