# Provider Referral Request Form

**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

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<tr>
<th>Referring Provider’s Name:</th>
<th>Phone:</th>
<th>Fax:</th>
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**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:

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<th>Preferred Phone:</th>
<th>Best time to call:</th>
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**Special Patient Considerations:**

**Patient Insurance Information:**

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<th>Patient’s Primary Care Provider:</th>
<th>Phone:</th>
<th>Email:</th>
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**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 Accepted?**
- [ ] Yes
- [ ] No: Explain

**Appointment Scheduled with:**

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<th>Date &amp; Time:</th>
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| [ ] 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:**