Ketamine Referral Form- Please send completed form to stacy@rejuvenateolympia.com or Fax to 360-688-1066

Referring Provider:____ Today's Date:____/____/ _____

Provider Office Contact:____
(Full Name/Telephone Number)

Patient's Name:______________________________ Date of Birth:____/____/ ____________
(First, Middle Initial, Last)

Diagnosis: ____

*****Please attach patient health history, medication & allergy list and last patient note addressing this referral.**

Patient's Contact Information:

Home/Cell phone:________________________ Other phone:________________________

Address: ____
(Street Address/City/State/Zip)

Insurance Plan Information N/A____
(Plan Name, Member I.D and/or Group Number, Please send copy of card)

Aki Anesthesia, PLLC at Rejuvenate provides Ketamine infusions for Depression, PTSD, Suicidal Ideations, Anxiety and Chronic Pain Syndrome.

Referral for:

- ☐ Ketamine for Pain (chronic/CRPS)
- ☐ Ketamine for Mental Health

Alki Anesthesia, PLLC Use only:

Appointment Date:_____/______/______ Time:__:______

If not scheduled, indicate reason and recommendation: ____

____

Provider's Signature:____ Date:_____/_____/_____ Time:_____:_____