Minnetonka
WELLNESS CENTER

Confidential Provider Referral

I am currently treating:

Patient Name:

Patient Date of Birth:

Patient Contact Phone Number:

Diagnosis: *Diagnostic codes must be listed with severity prior to submission for referral to be approved*

ICD-10 Code	Diagnosis

For patient transferring from another facility that currently receive ketamine therapy, list the following information:

Last ketamine dose (mg/kg)_____

Total dose administered (mg)_____ over_____minutes.

Any additional medications and dose administered prior to, during, or post infusion:

Additional diagnosis/conditions/comments:

I believe that ketamine infusion treatments may benefit my patient and am referring them for ketamine infusion therapy to Minnetonka Wellness Center LLC and their providers. I acknowledge and agree to collaborate with Minnetonka Wellness Center and their providers regarding the treatment of my patient. I acknowledge that I can contact Minnetonka Wellness Center to further discuss the treatment protocol and may further review information about this therapeutic treatment option. I will continue to follow and direct the care of my patient throughout this course of therapy or collaborate their care with a Primary Provider or Mental Health Provider.

_____ _____

Referring/Prescribing Provider Signature Date

_____

Printed Name

_____ _____

Clinic Name Phone Number

Referring Provider must submit completed form via email at
medicalrecords@minnetonkawellnesscenter.com