Genesys Infusion Center LLC
At EastPort Plaza
2515 N. Main St.
East Peoria, IL 61611
(309) 205-3533

Ketamine Referral Form

I am currently treating (patient name)_____

Date of birth_____

For: (list conditions and diagnosis)_____

_____

I feel that Ketamine infusion therapy may benefit this patient and I am referring him/her for evaluation as an adjunctive treatment for his/her diagnosis. I agree to collaborate with my patient's Ketamine provider regarding the treatment of my patient.

I acknowledge that I may contact my patient's provider to discuss the treatment protocol and may review more information about this therapeutic option at www.genesysinfusioncenter.com.

I will continue to follow and direct the care of m patient during and after the completion of the course of therapy and if applicable, will coordinate with his/her care with his/her primary care or psychiatric health care provider.

Provider signature and date:

Printed Name:

Phone number: _____

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