Provider Referral for Ketamine Infusion Therapy

Ketamine Infusion Provider:

I am currently treating (patient name): ____,

For (list conditions & diagnosis)____

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I feel that Ketamine infusion therapy may benefit this patient and 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 ketamine provider to discuss the treatment protocol and may review more information about this therapeutic option at www.ketaminewellnessinfusions.com or ketaminewellnessinfusions@gmail.com 615-987-0098

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

Provider Signature and Date:

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Printed name:

____

Phone Number:

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