ketamine america

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TREATMENT REFERRAL FORM

PATIENT INFORMATION

NAME: ____
(FIRST NAME) (LAST NAME)

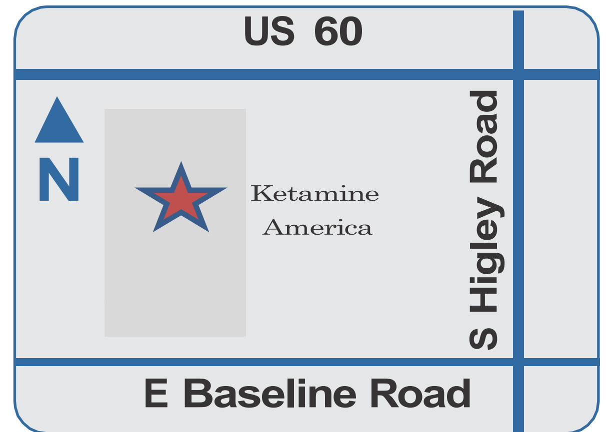
DOB: _______/__________/__________

EMAIL: ____

PHONE: ________________________

INSURANCE/IF APPLICABLE:

preferred contact method OR time: ______________________________



Referring PROVIDER/SPECIALTY

Provider Name: ____________________________________

Specialty:____

Phone:____________________ Fax:___________________
Email:____

PROVIDER SIGNATURE:

____

Please attach a current medication list, supporting clinical notes/psych eval or pertinent labs and imaging along with signed referral sheet. All referrals are contacted within 24-48 hours for consultation

REFERRAL Date: ____ /____ / ______

IS THIS A STAT REQUEST FOR PAIN? ______
IS THIS A STAT REQUEST FOR SUICIDE? ______
IS THIS A STAT REQUEST FOR OTHER? ______

Sent by:______________________________(Please print name)

TREATMENT (check all that apply)

- CHRONIC OR ACUTE PAIN
- DEPRESSION/ANXIETY
- PTSD
- ADDICTION MEDICINE
- ALCOHOL/OPIATE WITHDRAWL
- FIRST RESPONDER/HEALTHCARE COMPASSION FATIGUE/ANXIETY
- SOCIAL ANXIETY/SUICIDALITY teen/pre-teen/adult
- LYME DISEASE
- FIBROMYALGIA/ARTHRITIS
- COVID-19 STRESS/ANXIETY
- LONG HAULERS SYNDROME
- OTHER:_____________________________