PROVIDER REFERRAL FOR KETAMINE INFUSION THERAPY

PLEASE PRINT CLEARLY

Patient Name_____

Patient DOB_____ Phone_____ Email_____

Primary Diagnosis / Reason for treatment request_____

Has patient had unsatisfactory results with at least 2 other medication or treatment options? YES NO

Current Medication List_____

History & Physical / Recent Visit Notes / Recent Labs please fax to **423-765-0777** or email to **info@illuminateketaminecenter.com**

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 provider to discuss the treatment protocol and may review more information about this therapeutic option at illuminateketaminecenter.com

I will continue to follow 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 mental health provider.

Provider Signature

Printed Name

Phone Number

Date

CONFIDENTIAL

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