# REFERRAL FOR KETAMINE INFUSIONS

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REVIVE KETAMINE
KETAMINE INFUSION THERAPY

Date: _____

Patient Name: _____ Date of Birth: ____/____/_____

Patient Phone Number_____ Patient Email _____

Reason for Referral: _____

☐ MDD/TRD/PTSD ☐ OCD/ ANXIETY ☐ PAIN/CRPS ☐ OTHER

I am currently treating (patient name): _____

I am recommending ketamine infusion treatments at Revive Ketamine Centers as an adjunctive therapy with the diagnosis listed above

I acknowledge I may contact the provider to discuss protocol and options at: **info@reviveketaminecenters.com**

**Clinical Narrative** (if needed)

_____
_____
_____
_____

| **Medication Name** | **Dose** | **Date started** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

_____ _____

Referring Physician Printed Name Referring Physician Office Number

_____ _____

Referring Physician Signature Date