Pain and Mental Health Well-Being Treatment Center

CONFIDENTIAL

Provider Referral for (circle): **Intravenous Ketamine Infusion Therapy**

Dear DC Ketamine Clinic Provider:

I am currently treating (patient name) ____

for a **Mental Health-related diagnosis**: Major Depression / Bipolar Disorder / PTSD (add specific diagnosis as needed):

____

I am concerned about the severity of this patient's symptoms and/or have seen suboptimal

responses to multiple treatments, including:

____

I am referring this individual for consultation, evaluation, and administration of IV Ketamine Infusion Therapy as an adjunct therapy in the management of this illness.

I acknowledge that I may review information about this therapeutic option at www.dcketamineclinic.com and/or contact you at 443-535-1372 to discuss the treatment protocol.

I will continue to follow my patient during and after the completion of the course of IV Ketamine Infusion Therapy and will coordinate patient's psychiatric care treatment with patient's psychiatrist, specialist, or primary care provider.

Clinician signature: ________________________

Clinician Printed name:__________________________________

Clinician Phone: ______________________________

Clinician Email:____

Practice Address: ____

Fax:_____________________________________ Date:____

*Note: Please email all printed Clinician Referral Forms to: dcketamineclinic@gmail.com