Pain and Mental Health Well-Being Treatment Center

CONFIDENTIAL

Provider Referral for (circle-may select both): **Intravenous Ketamine Infusion Therapy**

Intravenous Lidocaine Infusion Therapy

Dear DC Ketamine Clinic Provider:

I am currently treating (patient name) ____

for a **Pain-related diagnosis**: CRPS / Fibromyalgia / Chronic Pain / Low Back Pain / pain management (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 or Lidocaine Infusion Therapy as adjunctive treatment 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 or Lidocaine Infusion Therapy and will coordinate patient's pain management care treatment with patient's 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