Provider Referral Form for Ketamine Infusion Therapy:

Patient's name: _____ DOB:_____ Phone #:_____

(list conditions & diagnosis)_____

_____

Current Medications:_____

_____

Allergies:_____

Recent Labs:_____

Special Considerations:_____

_____

Primary Care Physician or Mental Health Provider Information:

PCP/MHP Name:_____

Practice Name & Address:_____

PCP/MHP Phone #:_____ Fax:_____

I feel 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 Midwest Ketafusion regarding the treatment of my patient.

I acknowledge that I may contact Midwest Ketafusion to discuss the treatment protocol and may review more information about this therapeutic option at www.midwestketafusion.com/providers

_____ _____

Provider Signature Date

_____ _____

Printed Name Phone #

Please FAX completed forms to (319)-333-0624.

CONFIDENTIAL

phone:319-849-8114 email: mwketafusion@gmail.com
1700 South 1st Ave, STE 25A, Iowa City, IA 52240
www.midwestketafusion.com