Provider Referral for Ketamine Infusion Therapy

Ketamine Infusion Provider:

I am currently treating (patient name): _____,

For (list conditions & diagnosis)_____

_____

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 info@vitalitymedicalinfusions.com.

I will continue to follow and direct the care of 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 psychiatric physician.

Provider Signature and Date:

_____

Printed name:

_____

Phone Number:

_____