

**Ketamine Referral Form**

**Provider Referral for Ketamine Infusion Therapy at Greater Wellness Clinic**

Greater Wellness Clinic Ketamine Providers:

I am currently treating (patient name): \_\_\_\_\_,

For (list diagnosis & current therapy modality): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_.

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 [www.greaterwellnessclinic.com/providers](http://www.greaterwellnessclinic.com/providers).

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:

\_\_\_\_\_

\_\_\_\_\_

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[www.greaterwellnessclinic.com](http://www.greaterwellnessclinic.com)

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Please feel free to add free text here: