REFERRAL FOR KETAMINE TREATMENT

Today's Date:________
Patient Name:_______________________________________
DOB : ______________
Phone # : ____
Reason for Referral: **____**
Current / Prev. Diagnosis
:____
Time in Treatment:
____
Current
Medications:____
Previous failed treatments /
meds:____
Notes:____
____
Referring Physician's Name (please print) : ____________________________
Physician's signature : X ____________________________________
Phone # :
Email:
*Please send your office notes for the patient's last visit, recent lab work, EKGs, imaging, etc. via fax or
email along with this form.
Thank you for your referral of this patient. We look forward to collaborating with you to improve their health and
mental wellbeing.

Regards
Hagop Karpanian, MD