KETAMINE & INFUSION CLINIC
OF SOUTH FLORIDA

ketamineclinicsouthflorida.com | Office (954) 320-4944

Provider Referral Form for Ketamine Infusion Therapy

In order to provide immediate care, we need the following information sent to us. Once we have the patient's information, we will contact them and schedule their infusions.

Patient Information

Patient Name: _____ Patient DOB:_____

Phone Number (Home): _____ (Cell): _____

Patient Email: _____

Provider Information

Provider Name: _____

Phone Number: _____ Fax: _____

Provider Email: _____

Currently Treating patient for the following:_____
_____
_____

I feel that Ketamine infusion therapy may benefit this patient and am referring him/her for evaluation for Ketamine Infusion Therapy 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 http:// ketamineclinicsouthflorida.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: _____ Date: _____

Printed name: _____

Please send this information along with your patient's **most recent H&P/evaluation** to us via email, fax, or mail: **Email** contact@ketamineclinicsouthflorida.com **Fax** 954-400-5805 **Mail** 41 N. Federal Hwy, Suite A, Pompano Beach, FL 33062