NW Ketamine Infusion
Living your best life

Referral Form for Ketamine Treatment

Patient Name: _____

Patient DOB: _____

Referral Diagnosis and ICD10: _____

Current medications related to diagnosis:

_____

_____

Any previous medications or treatments attempted:

_____

_____

NW Ketamine Infusion provides treatments on a referral basis only. As anesthesia providers our expertise is limited to the use of ketamine to augment the patient's current treatment regimen. We do not provide mental health services or advice outside the limited scope of the infusions. The dosing, duration and frequency of infusions is determined by current evidence-based practice, with safety always being the top priority.

Referring Provider Name: _____

Referring Provider Signature: _____

Contact phone and/or email for care coordination: _____

Please contact NW Ketamine Infusion at any time with questions or concerns. Your referral is greatly appreciated.

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