



## Referral Form for Ketamine and/or Nitrous Oxide Treatment

**Please indicate the treatment(s) that the client may receive:**

Ketamine Infusion Therapy:

Nitrous Oxide Therapy:

Patient Name: \_\_\_\_\_

Patient DOB: \_\_\_\_\_

Referral Diagnosis and ICD10: \_\_\_\_\_

Current medications related to diagnosis:

\_\_\_\_\_  
\_\_\_\_\_

Any previous medications or treatments attempted:

\_\_\_\_\_  
\_\_\_\_\_

NW Ketamine Infusion provides treatment on a referral basis only. As anesthesia providers our expertise is limited to the use of ketamine or nitrous oxide to augment the patient's current treatment regimen. We do not provide mental health services or advice outside the limited scope of these treatments. The dosing, duration and frequency of treatment 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.