Specialized Infusions

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NEW PATIENT REFERRAL FORM

Please include the following information with this form:
- Last 2 treatment notes (required)
- Latest laboratory results (BMP/CMP, CBC, LFT's, thyroid panel, Vit B12 & D) and EKG if available

Patient Information

Patients Full Name: DOB: Phone:

Referral Diagnosis and ICD10:

Medical Comorbidities (e.g., heart, lung, liver, kidney disease):

Reason for Referral (please check box):

❑ Initial Series of ketamine infusions for mental health diagnoses (six infusions over a 2-3 week period)

❑ Other:

Does the patient have any of the following conditions?:
- Active mania Yes / No
- History of schizophrenia or psychotic features Yes / No
- Suicidal Ideation Yes / No (**if yes, please comment on risk assessment**)

Communication and Care Coordination: For the initial series of six infusions, we will send you an update after infusions 1, 3, and 6. We recommend that your patient schedule a follow-up evaluation during (when possible) and after the initial series in infusions. You, your patient, or Specialized Infusions may discontinue treatments at any time.
Continuing Treatment: We will send you a patient referral renewal form after the completion of the initial series. We will provide you with a recommended maintenance plan, which you may accept or alter as you see fit. Intervals of 3-6 weeks between maintenance infusions is common, but individual needs vary.

Additional information:

Referring Provider Information

Referring Provider: Speciality:

Phone: Fax:

Preferred communication (circle one): ☐ Email ☐ Fax ☐ Phone Email:

By signing below, I acknowledge that I feel that ketamine infusion therapy may benefit this patient and am referring him/her for ketamine treatments as an adjunctive treatment for his/her treatment resistant diagnosis. My patient does not have any known psychiatric contraindications to administration of ketamine. I agree to collaborate with Specialized Infusions regarding the treatment of my patient. I understand that Specialized Infusions does NOT provide mental health services, and I agree to be the patient's mental health contact. I will continue to follow and maintain primary responsibility for my patient during and after the completion of the course of therapy.

Signature: _____ Date: _____