Specialized Infusions

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PATIENT REFERRAL FORM

Please attach the following information with this form:

- Last treatment note addressing the referral diagnosis
- 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, plus 2 booster infusions)
- ❑ Maintenance Infusions (requires updated referral every 90 days)
- ❑ Other:

Does the patient have any of the following conditions? (Circle answer):

- 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 and 6. We recommend that your patient schedule a follow-up evaluation during (when possible) and after the initial series of infusions. You, your patient, or Specialized Infusions may discontinue treatments at any time.
Maintenance Treatment: We will send you a request for an updated referral after the completion of the initial series. We will provide you with a recommended maintenance plan, which you may alter as you see fit. Intervals of 3-8 weeks between maintenance infusions are common, but individual needs vary.

For Maintenance Infusion Patients: In your opinion, have treatments been helpful in controlling your patients symptoms? Yes / No

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: _____