Provider Referral Form
Ketamine Infusion Therapy

Dear Ketamine Infusion Provider,

I am currently treating (patient name): ____

for (conditions/diagnosis) ____

____.

I feel that Ketamine Infusion Therapy (IVKT) may benefit this patient and am referring him/her for evaluation 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 www.sunbeltwellness.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: __________________________________

Phone number: (______)______________

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CONFIDENTIAL

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