**Community Provider Referral for Ketamine Infusion Therapy**

**Referring Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

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

**Patient Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Behavioral Health Provider (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 Name Phone Number

**Indication(s) for Ketamine Therapy:**

⎕ Post Traumatic Stress Disorder (PTSD) or symptoms of PTSD

⎕ Depressive disorder (Major Depressive Disorder, Persistent Depressive Disorder, etc.) or symptoms of depression

⎕ Dysthymic Disorder

⎕ Seasonal affective disorder

⎕ Generalized Anxiety Disorder (GAD) or symptoms of anxiety

⎕ Sexual Assault

⎕ Obsessive Compulsive Disorder (OCD) or symptoms of OCD

⎕ Other:

**Patient/referral notes:**

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**Acknowledgements:**

I feel that Ketamine infusion therapy may benefit this patient and am referring him/her for evaluation as an adjunctive treatment for his/her diagnosis. I agree to collaborate with Elevated Health regarding the treatment of my patient.

I acknowledge that I may contact Elevated Health providers to discuss the treatment protocol and may review more information about this therapeutic option at [www.ElevatedHealthAugusta.com](http://www.ElevatedHealthAugusta.com).

I understand that Elevated Health does not provide primary medical or behavioral health care. I will continue to follow and direct the care of my patient during and after the completion of ketamine therapy, and if applicable, will coordinate care with his/her primary care or behavioral health provider.

Elevated Health does not bill insurance directly. However, a superbill will be provided upon patient request and we offer financing options.

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Provider Signature/Credentials Date

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Printed name

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Phone Number

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Email