New Patient Referral for Ketamine Infusion Therapy

Patent's Name: _____ Patient's DOB: _____

Phone Number: _____ Email: _____

I am currently treating this patient for a (choose one or multiple):

☐ Mental Health related diagnosis: Major Depression/Bipolar Disorder/PTSD/Anxiety/OCD/ Suicidality/Other: _____

☐ Pain related diagnosis: CRPS, Fibromyalgia, RSD, Chronic Migraines, Pain related to RA or MS, Neuropathy, Treatment Refractory Cancer Pain, Other: _____

☐ Other: _____

Referring Diagnoses:

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 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.ascendwellnessmbs.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 provider or specialist.

Provider Signature: _____

Printed name: _____ Date: _____

Phone Number: _____ Email: _____

Fax: _____

Please fax completed referral to 701-852-5075

Ascend Wellness MBS
2 South Main Street, Ste #115
Minot, ND 58701
701-501-6585