HQ

Patient Referral: Ketamine Wellness Clinic of Orange County

Patient's Name (Last, First): _____

Patient's Date of Birth: _____ Referral Date: _____

Patient's Phone (Home): _____ (Mobile): _____

Patient's Email: _____

Diagnosis (ICD 10 Code): _____

Referring Provider: _____ Specialty: _____

Provider's Email: _____

Provider's Phone: _____ Fax:_____

Reason for Referral: (Check all that apply) Include a Brief Description:

- ☐ Depression _____
- ☐ Obsessive Compulsive Disorder (OCD) _____
- ☐ Post-Traumatic Stress Disorder (PTSD _____
- ☐ General Anxiety Disorder _____
- ☐ Bipolar (Mania with Refractory Depression) _____
- ☐ Fibromyalgia _____
- ☐ Complex Regional Pain Syndrome (CRPS/RSD) _____
- ☐ Neuropathic Pain _____
- ☐ Migraines or Daily Headaches_____

Current Treatments:

- ☐ Medical Management _____
- ☐ Psychotherapy _____
- ☐ Other: _____

Checklist Prior to Referral: (note all boxes must be checked prior to clinic admission)

- ☐ Patient is not actively suicidal
- ☐ Patient is not actively abusing opioids or other illicit substances
- ☐ Patient consents to referral and understands the clinic obligations

Please FAX completed form to (949)499-7582

***Ketamine infusion therapy is one part of your patient's comprehensive treatment. We require patients to maintain continuity with their referring provider following the completion of their ketamine treatments.**

Referring Provider Signature: _____