PATIENT REFERRAL

KETAMINE WELLNESS CLINIC
ORANGE COUNTY

Please complete and send this form to Ketamine Wellness Clinic of Orange County.

Patient's Name (Last, First) _____

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

Mobile Phone (_____) _____-_____ Other Phone (_____) _____-_____

Patient's Email _____

Diagnosis (ICD 11 Code) _____

Referring Clinician _____ Specialty _____

Clinician's Email / Phone _____

Reason for Referral (Check all that apply and 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 _____
- ☐ History of Psychosis _____

Current Treatments (Check all that apply and include a brief description)

- ☐ 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

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

Referring Clinician Signature _____