## **PATIENT REFERRAL**



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

Patient's Date of Birth	Patient's Name (Last, First)
Patient's Email Diagnosis (ICD 11 Code) Referring Clinician	Patient's Date of Birth/ Referral Date/
Diagnosis (ICD 11 Code)  Referring Clinician	Mobile Phone () Other Phone ()
Referring Clinician Specialty	Patient's Email
Clinician's Email / Phone	Diagnosis (ICD 11 Code)
Reason for Referral (Check all that apply and include a brief description)  Depression D	Referring Clinician Specialty
□ 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	Clinician's Email / Phone
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Referring Clinician Signature	