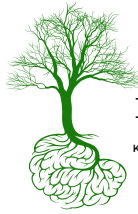


REFERRAL FOR KETAMINE INFUSIONS

☎ 470-389-5400

☎ FAX: 470-437-3215

✉ info@reviveketaminecenters.com



**REVIVE
KETAMINE**
KETAMINE INFUSION THERAPY

Date: _____

Patient Name: _____ Date of Birth: ____/____/____

Patient Phone Number _____ Patient Email _____

Reason for Referral: _____

MDD/TRD/PTSD

OCD/ ANXIETY

PAIN/CRPS

OTHER

I am currently treating (patient name): _____

I am recommending ketamine infusion treatments at Revive Ketamine Centers as an adjunctive therapy with the diagnosis listed above

I acknowledge I may contact the provider to discuss protocol and options at: info@reviveketaminecenters.com

Clinical Narrative (if needed)

Medication Name	Dose	Date started

Referring Physician Printed Name

Referring Physician Office Number

Referring Physician Signature

Date