



# RESTORING WELLNESS SOLUTIONS

## Provider Referral for Ketamine Infusion Therapy

---

I am currently treating (patient name): \_\_\_\_\_

For (list conditions & diagnosis) \_\_\_\_\_

---

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 will continue to follow and direct the care of my patient during and after the completion of the course of therapy.

Provider Signature:

Date:

\_\_\_\_\_

\_\_\_\_\_

Printed name:

\_\_\_\_\_

Phone Number:

\_\_\_\_\_