



4300 Bayou Blvd. – Suite 27
Pensacola, FL 32503
800-850-6979

REFERRAL FORM

Thank you for choosing to refer your patient to us. To begin the referral process, please fax this form to the Ketamine Institute at 850.602.9013 or scan/email to restore@ketamineinstitute.com

Please include brief pertinent patient medical records including the last 2-3 treatment visits that support the consultation. Also recent laboratory results including CBC, serum electrolytes, LFT's, Thyroid Profile, B12 levels and an EKG would be helpful.

Date:	From:
No. of pages:	Title:
To: Ketamine Institute	Phone:
Fax: 850.602.9013	Fax:

PATIENT INFORMATION

Name of patient:	
DOB:	SSN:
Home phone:	Cell phone:
Address	
City:	Zip:

CONSULTATION REQUEST INFORMATION

Diagnosis/ICD 10:
Pertinent Co-morbidities:
Reason for Consultation:

By providing the information requested and signing below, you agree that we may initiate treatment following consultation or perform medically necessary diagnostics in association with this consultation. We look forward to collaborating with you on your patient's treatment plan.

REFERRING PHYSICIAN INFORMATION

Referring MD:	Specialty:
Phone:	Fax:
PCP name:	Phone:
Signature	

NOTICE OF CONFIDENTIALITY: This is a confidential fax and is intended solely for the person/institution indicated above. If you are not the intended person, you are hereby notified of the confidential nature of this fax and that you are not entitled to read, copy or otherwise disseminate any of the information contained herein.