Referral Form
Awakenings Infusion Center of North Carolina, PLLC

Provider Referral for Ketamine Infusion Therapy

Mental Health Care or Primary Provider:

I am currently treating (patient name): _____

For the following conditions and diagnoses:

_____

_____

_____

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 agree to collaborate with my patient's ketamine provider regarding the treatment of my patient.

I acknowledge that I may contact my patient's provider to discuss the treatment protocol and may review more information about this therapeutic option at www.ncawakenings.com.

I will continue to follow and direct the care of my patient during and after the completion of the course of therapy and if applicable, will coordinate his/her care with his/her primary care or psychiatric physician.

Provider Signature: _____ Date: _____

Printed Name: _____ Specialty: _____

Phone Number: _____

CONFIDENTIAL

The completed form may be provided to the patient or faxed to (919) 590-1599.