

**Provider Referral**

**Ketamine Infusion Treatments**

**🕿678-438-8732 🖷 FAX: 678-730-3127 🖂** **chris.fitzpatrick@georgiaketamine.com**

 **c/o: ketaminegeorgia@gmail.com**

Date:\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MDD/TRD/PTSD OCD/ ANXIETY PAIN/CRPS OTHER

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

I am recommending Ketamine infusion Treatments at Invictus-Ketamine Clinic as an adjunctive therapy with the diagnosis listed

 I acknowledge I may contact the provider to discuss protocol and options: **chris.fitzpatrick@georgiaketamine.com** **or c/o: ketaminegeorgia@gmail.com**

Clinical Narrative (if needed)

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Medication Name, Dose and Date started:

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 **Provider Signature Date**

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 **Printed Name Phone Number**