**Clinician Referral Form for Ketamine Treatment at Mental Health Center**

I am currently treating _____ for the diagnosis of:

Major Depression  Bipolar Disorder  Generalized Anxiety  PTSD  Other: _____

I am concerned about the severity of this patient's symptoms which include:

_____

_____

I am aware of or have seen this patient's suboptimal response to multiple treatments, including:

- Failed medication trials (name, dose, directions, duration, beneficial effects, side effects):

  _____

  _____

  _____

  _____

  _____

  _____

  (Please mark current medications with an "*")

- Failed psychotherapy modalities (include yearsor number of sessions) or IOP/RTC:

  _____

  _____

- Failed procedural treatments: ☐rTMS  ☐ECT  ☐Other:_____

This patient would like to initiate ketamine therapy as an adjunct to the management of this illness. I acknowledge that I may review information about this therapeutic option at www.MentalHealthCtr.com and/or contact you at Office@MentalHealthCtr.com or (310) 601-9999 to discuss the treatment protocol. I will follow-up with this patient during and after the completion of the treatment course at Mental Health Center or refer him or her to a licensed mental health provider for follow-up.

Clinician signature: _____
Printed name: _____

Contact information:

_____

_____

Other healthcare providers in this patient's case include (with email address or phone numbers):

Psychotherapist:_____

Psychiatrist:_____

Primary Care Physician:_____

Others:_____