



Physician/Mental Health Professional Referral

PATIENT INFORMATION:

Name: _____ DOB: _____ Phone Number: _____

TREATING PHYSICIAN OR MENTAL HEALTH PROFESSIONAL INFORMATION:

Name: _____ Specialty: _____

Email: _____ Phone No: _____ Fax No: _____

I am currently treating this patient for the following diagnos(es):

Patient's current psychiatric medications (you may attach a list if preferred):

Patient's previous psychiatric medications: (you may attach a list if preferred)

Do you believe this patient may have an active substance use disorder? _____

Please circle any of the following contraindications:

- Uncontrolled hypertension
- Unstable heart disease
- Untreated hyperthyroidism or tachycardia
- Raised intracranial or intraocular pressure
- Urinary incontinence, urgency or pain
- Pregnancy
- Psychosis, schizophrenia, current mania
- Seizure disorder
- Currently on lamotrigine (Lamictal) or regular benzodiazepine use
- MAOI antidepressant treatment

Texas Ketamine Specialists's treatment protocol:

1. Patient will be contacted by our office for screening and scheduling. They will be provided with pre-procedure instructions. A deposit of \$150 will be taken at that time to pay for the initial consultation. If they are approved for ketamine therapy and proceed with the first infusion, the \$150 dollars will be applied towards their first infusion. Each infusion costs \$500.
2. We will check their mood throughout their weeks of treatment, and after the sixth infusion, we will determine whether ketamine has been effective for their treatment resistant depression. For the responders, maintenance infusions (\$500 each) will be scheduled. On average, maintenance infusions are between 6 to 8 weeks.
3. We use an app-based program called Osmind to document their moods (www.osmind.org) and track progress.
4. We reach out and notify you about the patient's progress.

Please read the following and sign below:

- This patient and I would like to initiate ketamine infusion therapy as an adjunct to the management of the above illness.
- I acknowledge that I may review information about this therapeutic option at <https://texasketaminespecialists.com/> and that I may contact Texas Ketamine Specialists to discuss treatment.
- I will follow up with this patient during and after the completion of the treatment course a Texas Ketamine Specialists or refer him or her to a licensed medical professional for follow-up.

Physician Signature

Date

We appreciate the opportunity to collaborate with you in improving your patient's mental health.

Please return the completed form:

Fax: 508.619.4925

Email: rdoxey@texasketaminespecialists.com

Mail: Texas Ketamine Specialists, 12740 Hillcrest Rd. Suite 295, Dallas, Texas 75230