Texas Ketamine Specialists™

Physician/Mental Health Professional Referral

PATIENT INFORMATION:

Name: Date Of Birth: Phone Number:

_____ _____ _____

TREATING PHYSICIAN/MENTAL HEALTH PROFESSIONAL INFORMATION:

Name: Speciality:

_____ _____

Email: Phone Number: Fax Number:

_____ _____ _____

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

_____

_____

Patient's current and past 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 that may apply to this patient:

- Urinary incontinence, urgency or pain
- Unstable heart disease
- Untreated hyperthyroidism or tachycardia
- Currently on Lamictal (lamotrigine) or regular benzodiazepine use
- Raised intercranial or intraocular pressure.
- Seizure Disorder
- Uncontrolled hypertension
- Pregnancy
- MAOI antidepressant treatment
- Urinary incontinence, urgency or pain

Texas Ketamine Specialists infusion treatment protocol:

1. Patients will be contacted by our office for screening and to schedule an initial evaluation. They will be provided with pre-procedure instructions. Upon approval for ketamine infusion treatment, patients may proceed with their first infusion directly following the evaluation. For patients beginning ketamine infusion treatment, the protocol we follow is a series of six infusions, twice weekly.
2. Payment of initial evaluation ($150) is due at the time appointment is booked. This fee will be deducted from the cost of the first infusion.
3. Patient symptoms will be followed throughout the weeks of their initial treatment. Upon completion of the last infusion, a determination will be made as to the effectiveness of ketamine infusion treatment. For the responders, maintenance infusions will be scheduled. These are single infusions, scheduled, on average, every four to eight weeks. We advise patients to schedule maintenance infusions if their symptoms return for three to four consecutive days.

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 disorder and/or symptoms listed above.
- I acknowledge that I may review information about this therapeutic option at texasketaminespecialists.com
- I will follow up with this patient during as well as after the completion of the treatment course at Texas Ketamine Specialists or refer him/her to a licensed medical professional for follow-up.

_____ _____

Physician or Medical Health Provider Signature Date

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

Please return the completed form to:

Fax: 508.619.4925

Email: rdoxey@texasketaminespecialists.com

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