InVigorate Asheville

Your Path to Wellness

**Invigorate Asheville Ketamine Referral Form**

Patient Name: _____Date: _____
Patient DOB:_____Patient Phone: _____
Address: _____
MedicalDiagnoses:

_____

_____

Current Medications and Doses: (for psychiatric or other medical conditions)

_____

_____

Reason for Referral:

_____

_____

_____

If known, please note any positive history of the conditions below by checking the appropriate boxes.

☐ Substance use disorder. Please note substance(s) used: _____

☐ History of treatment with ECT, TMS, or Ketamine: _____

Referring Clinician: _____

Address: _____

Phone: _____ Fax: _____Email:_____

If available, please attach any documentation you feel may be helpful (i.e., Initial H and P, recent progress note). A completed referral form is required before a patient may complete his/her first Ketamine Service visit. The completion of this referral indicates that you will continue to follow this patient through the course of their Ketamine treatments.