MINNESOTA
Ketamine & Wellness
INSTITUTE

The Minnesota Ketamine & Wellness Institute

Confidential Provider Referral Form

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I am currently treating (patient name): _____

Date of Birth: _____ Patient contact phone number: _____

For the following diagnosis/conditions: _____

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_____

I believe that ketamine infusion treatments may benefit my patient and am referring them for ketamine infusion therapy. I acknowledge and agree to collaborate with MKW Institute regarding the treatment of my patient.

I acknowledge that I can contact MKW-Institute to further discuss the treatment protocol and may further review information about this therapeutic treatment option. I will continue to follow and direct the care of my patient throughout this course of therapy or collaborate their care with a primary provider or mental health provider.

_____ _____

Referring Provider Signature Date

_____ _____

Printed Name and Clinic Name Phone number

Fax or email completed form to 763-432-5721 or info@mkw-institute.com

This form must be returned directly through the office of the referring provider. It cannot be submitted by the referred patient.