MINNESOTA
Ketamine & Wellness
INSTITUTE

Confidential Provider Referral Form

I am currently treating (patient name): _____

Date of Birth: _____ Patient contact phone number: _____

Diagnosis: **Diagnostic codes must be listed with severity prior to submission for referral to be approved**

ICD-10 Code	Diagnosis

For patients transferring from another facility that currently receive ketamine therapy, list the following information:

Last ketamine dose (mg/kg): _____ total dose administered (mg): _____ over_____ minutes.

Any additional medications & dose administered prior to, during, or post infusion:

_____

_____

Additional diagnosis/conditions/comments:

_____

_____

I believe that ketamine infusion treatments may benefit my patient and am referring them for ketamine infusion therapy to the Minnesota Ketamine & Wellness Institute, Maple Grove, Minnesota. 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/Prescribing Provider Signature Date

_____ _____

Printed Name and Clinic Name Phone number

Referring provider must submit completed form via Fax 763-432-5721 or email info@mkw-institute.com