406 SE 131st Ave Suite 203 Vancouver, WA 98683

Physician or HCP Referral

This form is to be completed by the referring MD or Health Care Professional.

Patient Name & Ph # _____ Date of Birth_____

MD or Provider Name_____ Specialty_____

MD or Provider Email_____ Phone_____

I am currently treating this patient for: _____

This patient and I would like to initiate Ketamine infusion therapy as an adjunct to the management of this illness.

I acknowledge that I may review information about this therapeutic option at remedyroompnw.com and that I may contact Remedy Room to discuss the treatment at **360-931-1223** or email **jen@remedyroompnw.com**.

MD or Provider Signature_____ Date_____