CLINICIAN REFERRAL FORM

I am currently treating ___________________________________ for major depression / bipolar disorder / or ____.

Because I am concerned about the severity of this patient's symptoms and/or they have had suboptimal response to multiple treatments, this patient and I would like to intitiate ketamine infusion therapy as an adjunct to the management of this illness.

I acknowledge that I may review information about this therapeutic option at www.tryketamine.com and/or contact at **317-777-1034** to discuss this treatment protocol.

I will continue to follow with this patient during and after the completion of the treatment course at Klarity Ketamine Wellness Clinic or refer him or her to a licensed mental health provider for follow-up.

CLINICIAN SIGNATURE: _______________________________________ DATE: ______________

PRINTED NAME: ____

CONTACT INFORMATION: ____