Please fax to 812-957-0011 or email to trubloom@vanishedaesthetics.com

KETAMINE THERAPY REFERRAL FORM

Patient's Name: _____Date of Birth: _____

Dear TruBloom Ketamine Team,

I am currently the treating provider for the patient listed above and believe they are an appropriate candidate for ketamine therapy as an adjunct to treatment for the following condition(s):

( ) Treatment-Resistant Depression (F33.2)
( ) Major Depressive Disorder (F32.9 / F33.1)
( ) Generalized Anxiety Disorder (F41.1)
( ) Post-Traumatic Stress Disorder (F43.10)
( ) Bipolar Disorder (F31.9)
( ) Chronic Pain (G89.4)
( ) Other (include ICD-10): _____

Recent Clinical Scores (if available):

PHQ-9 Score: _____ Severity: ☐ Mild ☐ Moderate ☐ Moderately Severe ☐ Severe

GAD-7 Score: _____ Severity: ☐ Mild ☐ Moderate ☐ Severe

I certify that the patient has demonstrated inadequate response to standard treatment modalities including pharmacotherapy and/or psychotherapy. We are seeking ketamine therapy to improve clinical outcomes. I agree to collaborate in the patient's care and remain involved throughout the course of treatment, including follow-up and maintenance planning as appropriate.

Referring Provider Name: _____Title: _____

License Number: _____NPI: _____

Email: _____Phone:_____Fax:_____

Signature: _____ Date: _____