McLean HOSPITAL
HARVARD MEDICAL SCHOOL AFFILIATE

Ketamine Service Clinician Referral Form

Please download this form before filling it out. Please type or print clearly.

Patient Name: ____ **Date:** _______________

Patient DOB: ________________________ **Patient Phone:** ______________________________

Address: ____

Diagnosis: ____

Reason for Referral:

____

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____

Current Medications and Doses: (for psychiatric or other medical conditions)

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____

Medical Diagnoses:

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Is an Axis II disorder thought to be a significant contributor of this patient's illness? **Yes** **No**

If known, please note any positive history of the conditions below by checking the appropriate boxes.

Substance use disorder. Please note substance(s) used: _____________________________________

History of treatment with ECT, TMS, or ketamine: ____

Referring Clinician Name: ____

Address: ____

Phone: ___________________ **Fax:** _____________________ **Email:** _____________________

If available, please attach any documentation you feel may be helpful (i.e., Initial H and P, recent progress note).

A completed referral form is required before a patient may complete his/her first Ketamine Service visit. If you have any questions regarding ketamine therapy, please call 617.855.2364.

Please fax the completed form to 617.855.3810 or mail to McLean Hospital, Attn: Ketamine Service, 115 Mill Street, Belmont, MA 02478.