MASSACHUSETTS MIND CENTER

Ketamine Service Clinician Referral Form (For Providers)

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:
_____
_____
_____
_____

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

Medical Diagnoses:
_____
_____

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

If known, please note any positive history of the conditions below.

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 617-236-2193
Please fax the completed form to 617-536-0324