MARQUETTE MEDICAL
MINDFUL WELLNESS
700 W Washington St, Suite B, Marquette, MI 49855
Phone: (906)239-3993, Fax: (906)239-3223

Referral For Ketamine Infusion Therapy

Contraindications: uncontrolled hypertension, angina, severe respiratory illnesses, or anything that would be considered a risk for outpatient procedures. Chronic use of high doses of benzodiazepine or THC also may impact response to Ketamine.

Please fax completed form, latest progress note, and patient demographics to 906.239.3223

REFERRING CLINICIAN			
Provider Name:	Practice/Clinic Name:		
Phone:	Fax:		
PATIENT DEMOGRAPHICS:			
Name:	DOB:	Birth Sex:	Pronouns/ Pref. Name:
Address/ City/ State/ Zip:	Phone: Email:		

PATIENT HISTORY:

- ☐ **Major Depressive Disorder**
- ☐ **Generalized Anxiety Disorder**
- ☐ **Substance Use Disorder**
- ☐ **Bipolar Disorder**
- ☐ **Postpartum Depression**
- ☐ **OCD**
- ☐ **PTSD**
- ☐ **Other:** ________________________

Medical History

- ☐ **Uncontrolled HTN**
- ☐ **Aneurysm in any location**
- ☐ **Ocular surgery or glaucoma**
- ☐ **Unstable angina**
- ☐ **Severe respiratory illness**
- ☐ **Other:** ________________________

History of Psychotherapy: YES / NO	Psychotherapy Dates:

Failed Medications Used for Depression in the Past Year:	Max Dose Used	Start Date	Stop Date	Response	Discontinued for side effects/lack of efficacy?
				☐ None ☐ Partial ☐ Transient	

Provide a summary of previous Ketamine, TMS or ECT treatments, if applicable. Please include dates and numbers of treatments, responses and/or complications.

History of Psychiatric Admissions, Suicide Attemps, Psychotic Episodes, and Substance Use Disorder:

Provider Name:______________________________

Provider Signature:____________________________ Date:___________