



Patient Name: _____ Date: _____

Patient DOB: _____ Phone Number: _____

Address: _____

Referring Physician: _____ Phone Number: _____

Medical Diagnoses: _____

All Current Medications & Doses: _____

Allergies: _____

Reason for Referral: _____

If known, check any conditions that apply :

Substance use disorder (Note: Substance(s) used): _____

History of treatment with ECT, TMS or ketamine _____

(Please describe):

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 consultation visit. If you have any questions regarding ketamine therapy and our clinic, please call **828-608-0892**

***Please send completed form by fax: 828-608-0373 or email: services@zenpsychiatric.com**