

Ketamine IV Infusion Therapy

Date: _____

To (Receiving Provider / Facility):

Rittenhouse Internal Medicine

1632 Pine St

Philadelphia PA, 19103

Phone: 215-735-7992 ext 217

Fax: 215-735-7991

info@bhwwc.com

From (Referring Provider / Office): Provider: _____

Practice/Organization: _____

Address: _____

Phone: _____ Fax: _____

Email: _____

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Age: _____ Gender: _____

Address: _____ Phone: _____

Email: _____

Emergency Contact: _____ Relationship: _____

Emergency Phone: _____

INSURANCE INFORMATION (If Available)

Insurance Provider: _____ Plan Name/Type: _____

Policy Number: _____ Group Number: _____

Subscriber Name: _____ Relationship to Patient: _____

REASON FOR REFERRAL

Clinical Reason for Referral (psychiatric/therapeutic context):

DIAGNOSIS

Primary Psychiatric Diagnosis:

Secondary / Comorbid Psychiatric Diagnoses:

Relevant Medical Diagnoses:

(DSM-5 / ICD-10 Codes if available): _____

TREATMENT HISTORY

Summary of psychiatric/therapeutic treatment history (modalities, duration, response):

Relevant medical treatments impacting psychiatric care:

Summary of previous and current treatments (including dates and response):

CURRENT MEDICATION LIST (Psychiatric and Relevant Medical Medications)

Medication Name | Dose | Frequency | Start Date | Prescribing Provider

Allergies / Adverse Reactions:

RELEVANT MEDICAL AND PSYCHIATRIC HISTORY

Psychiatric History (symptoms, onset, severity, prior episodes):

Medical History relevant to psychiatric care:

Substance Use History (if applicable):

Risk History (suicidality, self-harm, aggression) – if clinically appropriate:

Medical History:

Psychiatric History:

Hospitalizations / Surgeries (if relevant):

ADDITIONAL INFORMATION

Relevant labs, imaging, assessments, or attachments included: Yes No

Details:

REFERRING PSYCHIATRIC / THERAPY PROVIDER SIGNATURE

Provider Name: _____ Signature: _____

Date: _____