REFERRAL FOR KETAMINE TREATMENT

PORTLAND
KETAMINE
CLINIC

P-503-207-4992

F-503-961-8959

EMail - info@PortlandKetamineClinic.com

1815 SW Marlow Ave

Suite #112

Portland OR 97225

Patient Name: Todays Date :

DOB :

Ph # :

Reason for Referral:

____

Current / Prev. Diagnosis :______________________________

Time in Treatment: __________________________________

Current Medications:__________________________________

Previous Failed treatments / meds:_________________________

Notes:____

Referring Physicians Name (please print) : ___________________

Physicians signature : X ________________________

Phone # :

-Please attach your office notes for the patients last visit.

Thank you for your referral of this patient. We look forward to collaborating with you to improve their health and well being.

Best regards,

Dr. Enrique Abreu

Medical Director Portland & Seattle Ketamine Clinics