Palomar KLN
INFUSION CENTER

New Patient Referral

Patient's Name:_____________________________________**Patient's DOB:** ____________________

Diagnosis:____**Phone Number:**__________________

Ketamine/Lidocaine Infusion Provider: Palomar KLN Infusion Center

I am currently treating this patient for a (choose one or both):

Mental Health related diagnosis: Major Depression/Bipolar Disorder/PTSD/Anxiety/OCD/ Suicidality/Other ______________________________________

Pain related diagnosis: CRPS, Fibromyalgia, RSD, Chronic Migraines, Pain related to RA or MS, Neuropathy, Treatment Refractory Cancer Pain, Other ________________________________

I feel that Ketamine or Lidocaine infusion therapy may benefit this patient and am referring him/her for evaluation as an adjunctive treatment for his/her diagnosis. I agree to collaborate with my patient's Ketamine/Lidocaine provider regarding the treatment of my patient.

I acknowledge that I may contact my patient's provider to discuss the treatment protocol and may review more information about this therapeutic option at www.palomarkln.com.

I will continue to follow and direct the care of my patient during and after the completion of the course of therapy and if applicable, will coordinate his/her care with his/her primary care provider or specialist.

Provider Signature: **Date:**

_________________________ ____________________

Printed name: **Phone Number**

_________________________ ____________________