GENESIS PAIN CLINIC

6700 W 121st St | Suite 300 | Overland Park, KS | 66209
P: (913) 871-9888 | F: (913) 871-1477
admin@GenesisPain.com | www.GenesisPain.com

Ketamine Infusion Treatment Referral Form

Referring Psychiatrist: ______________________ Recommended Infusion Start Date: ________________

Primary Diagnosis: ________________________ Secondary Diagnosis: ____________________________

Recommended Starting Dosage (in mg/kg body weight): ____

Patient Body Weight (in kg): _________________ Patient BMI: __________________________________

Submit all completed forms below as part of consultation:

____ Request for Ketamine Infusion Treatment

____ Office Visit Notes

____ Health History Form

PATIENT INFORMATION

Last Name: ________________________________ First Name: _________________________________

Date of Birth: ___ / ___ / ___ Gender: [ ] Female [ ] Male

Address: ___________________________ City: __________________ State: ____ Zip: _________

Phone Number: _____________________ **Email Address:** _________________________________

Primary Language: [ ] English [ ] Spanish [ ] Other: _________________

____ ________________________________

Referring Provider Signature Date

Please complete and submit this document via fax to (913) 871-1477

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Past Medical History

- ☐ Atrial Fibrillation
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Blood Clots/DVT
- ☐ Bronchitis
- ☐ Cancer
- ☐ Crohn's Disease
- ☐ COPD
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Diabetes Type I or II
- ☐ Emphysema
- ☐ Fibromyalgia
- ☐ Epilepsy
- ☐ GI Ulcer
- ☐ Heart Attack
- ☐ Heartburn
- ☐ Hepatitis
- ☐ Liver Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Kidney Disease
- ☐ Lung Disease
- ☐ Mental Health Disease
- ☐ Multiple Sclerosis
- ☐ Neuropathy
- ☐ Organ Transplant
- ☐ Osteoporosis
- ☐ Pacemaker/ Defibrillator
- ☐ PTSD
- ☐ Pulmonary Embolus
- ☐ Rheumatoid Arthritis
- ☐ Sickle Cell Disease
- ☐ Sleep Apnea
- ☐ Spine/Neck Disorder
- ☐ Stomach Ulcers
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Vascular Disease/Stents

Are you allergic to any of the following?

- ☐ Steroids
- ☐ Penicillin
- ☐ Latex
- ☐ Iodine
- ☐ Sulfa Drugs
- ☐ Contrast Dye
- ☐ N.K.D.A.

If allergic, what was your reaction?

____

Other drug allergies and reactions (if applicable):

____

Medication List:

Medication Name	Dosage	Frequency	Reason

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Surgical History

Date	Procedure / Surgery

Anesthesia History: Please select the following if applicable.

- ☐ Have you had general anesthesia or sedation before?
- ☐ Did you have any complications with the anesthesia?
- ☐ Were you told it was difficult to insert the breathing tube?

Please elaborate if you checked any of the options above:
____
____

Social History: Please check all that apply.

- ☐ I smoke tobacco products.
  - o Type: ___________________ Number Per Day: _________________ Years Smoking: _________
- ☐ I use alcohol.
  - o How many drinks? _________________ How often? _________________

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Patient Agreement & Consent to Treatment

I ______________________ give my psychiatrist consent to release my information and all necessary documents to Genesis Pain Clinic for ketamine infusion treatment. I am aware that Genesis Pain Clinic will adhere to my psychiatrist's privacy policy as it relates to my medical information.

I ______________________ understand that ketamine infusion treatment will not be billed through my insurance and that I will be responsible for all fees related thereto. I authorize Genesis Pain Clinic to contact myself in regards to medical or financial information related to my ketamine infusion treatment.

________________________________	______________________________	_________________
Patient Name Printed	Patient Signature	Date

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