The Infusion Clinic of Ocala
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THE INFUSION CLINIC OF OCALA

Provider Referral for Ketamine Infusion Therapy

Dr. Milbrandt:

I am currently treating (**patient name, DOB, phone**):_____

_____,

for (list related conditions)_____

_____

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

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

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

If you are a physician (MD or DO), do you hold a medical license to practice in the state of Florida?

Yes ☐ No ☐ N/A ☐ I am not a physician (MD, DO) ☐

Provider Signature and Date:

_____

Printed name:

_____

Phone Number:

_____