restoratIV
KETAMINE WELLNESS CENTERS

acknowledgement of ongoing care form

Patient Name:			
Diagnosis/Diagnoses:			
Provider's Specialty:			
Provider's Phone Number:			
Provider's Fax Number:			
Provider's Email Address:			
Are you aware of any history of psychosis in this patient?*			
Additional comments:			
Signature of Provider:		Date:	

You may review information about ketamine therapy at our practice website: www.restorativ.com. Our physicians welcome any questions you have.

*Psychosis and mania are contraindications to ketamine treatment