Wayfound

# KETAMINE ASSISTED PSYCHOTHERAPY REFERRAL FORM

## Patient Information

| | | |
|---|---|---|
| Last Name *(Legal)*: | First Name *(Legal)*: | |
| Preferred Name: | DOB *(mm/dd/yyyy)*: | |
| Alberta Health Care #: | WCB #: | |
| Email: | Phone (1): | Phone (2): |
| Patient Address: *Unit/Street No. Street Name City Province Postal Code* | | |

**Additional Patient Information**

- ☐ Patient has a guardian
- ☐ Patient has an alternative contact
- ☐ Patient has vision requirements
- ☐ Patient has hearing requirements
- ☐ Patient has physical limitations
- ☐ Patient is unable to communicate in English

## Referrer Information

| | |
|---|---|
| Date of Referral *(mm/dd/yyyy)*: | |
| Referring Clinician: | PracID: |
| Clinic: | Phone: |
| Clinic Address: | Fax: |
| Family Physician *(If different from above)*: | PracID: |
| Clinic: | Phone: |
| Clinic Address: | Fax: |

## Referral Information

Is this referral in relation to an active WCB claim for this patient? ○ Yes ○ No

| | | | |
|---|---|---|---|
| Priority of Referral | ○ Routine | ○ Urgent | ○ Emergent |
| Patient's Current State | ○ Stable | ○ Worsening | |

| | |
|---|---|
| Active Medications | Active Medical/Psychological Conditions |

Referral Details:

## Completed By:

| | | |
|---|---|---|
| Name | Signature | Date |