NEUROHAVEN

Patient Referral Form

NeuroHaven Mental Health Clinic **Address**: 8905 W Post Rd Ste 110, Las Vegas, NV 89148 **Phone:** (725) 217-3519 **Fax:** (725) 348-0846 **Email:** Info@neurohavenmhc.com **Website:** www.neurohavenmhc.com	**PATIENT INFORMATION** Full Name: _____ Date of Birth: _____ Phone Number: _____ Home Address: _____ City:_____ State:_____ Zipcode: _____ E-mail: _____

Referring Provider Information

Provider Name: _____

Clinic Name: _____ Address: _____

Phone: _____ Fax: _____ Email: _____

Reason for Referral:

Primary Concern / Diagnosis: _____

Symptoms / Relevant History:

_____

_____

Ketamine Treatment Information

- Has the patient previously received ketamine treatment? □ Yes □ No
  If yes, please describe: _____
- Preferred route:
  - ☐ IV Infusion
  - ☐ Intranasal (Compounding)
  - ☐ Unsure
- **Transportation Needs**
  - ☐ Patient has their own driver
  - ☐ Please arrange NeuroHaven driver for patient
- **Preparation & Integration Support**
  - ☐ Included through NeuroHaven
  - ☐ Provided by referring provider/therapist

(Note: For safety reasons, patients cannot drive themselves after treatment)

Clinic Option for Ketamine Services

☐ Patient will receive ketamine treatment at **NeuroHaven Clinic**
☐ Patient will receive ketamine treatment at **Referring Provider's Clinic**
(Ketamine sessions provided on-site at your clinic are $250 per treatment paid upon booking. Referring

providers may add their own margin as appropriate.)

Supporting Documentation

- ☐ Medical Records
- ☐ Medication List
- ☐ Other documents: _____

Signature & Authorization

Referring Provider Signature: _____ Date: _____

Please complete form and attach any necessary documents. Submit form via fax (725) 348-0846 or e-mail: info@neurohavenmhc.com