



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)

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