Pain Physician Referral Form

Your patient_____ has contacted us concerning **Ketamine Infusion Therapy** as part of the treatment for their chronic pain. If you agree that ketamine infusion therapy might help this patient, I ask that you refer him/her to us, and provide a summary of the patient's pain, treatment and treatment response to date. Please call me to discuss this or other patients, and our protocol.

Best wishes,

Glen Z. Brooks, MD
Glen Z. Brooks, MD
Bd. Cert. Anesthesiologist
g.brooks@nyketamine.com
917-261-7370

Summary:_____
_____
_____
_____
_____

Physician Name: _____ Signature: _____

Date: _____

Office phone: _____ Office Fax: _____

Address: _____
_____
_____
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