LIGHTHOUSE
WELLNESS CENTER, PLLC

Frank Ferrer, M.D., Anesthesiologist
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Email: anesthesiact@gmail.com

PATIENT REFERRAL FORM

To be completed by referral source

I am currently treating (patient name) _____ DOB: _____

For (list conditions and diagnosis):

_____

_____

_____

I feel that Ketamine Infusion Therapy may benefit this patient and I am referring him/her for evaluation as an adjunctive treatment for his/her diagnosis. I agree to collaborate with Dr. Frank Ferrer regarding the treatment of my patient.

I acknowledge that I may contact Dr. Frank Ferrer to discuss the treatment protocol and may review more information about this therapeutic option.

I will continue to follow and coordinate the care of my patient during and after the completion of each Ketamine Infusion Therapy treatment.

_____ _____

Provider Signature Date

Provider printed name: _____

Phone number: ( ) - Provider email: _____

_____

CONFIDENTIAL

Please email this completed form to: anesthesiact@gmail.com

Mail to: Lighthouse Wellness Center
469 W Main St, Suite 1
Branford, CT 06405