



Physician/Mental Health Professional Referral

Patient Name and Date of Birth

Patient Phone Number

Physician/Mental Health Professional Name

Specialty

Physician/Mental Health Professional Email

Professional's Phone

I am currently treating this patient for the following diagnosis(es):

Patient's current psychiatric medications:

Patient's previous psychiatric medications:

Do you believe this patient may have an active substance use disorder? _____

Please check any of the following contraindications:

- Uncontrolled hypertension
- Unstable heart disease
- Untreated hyperthyroidism or tachycardia
- Raised intracranial or intraocular pressure
- Urinary incontinence, urgency or pain
- Pregnancy
- Psychosis, schizophrenia, current mania
- Seizure disorder
- Currently on lamotrigine (Lamictal) or regular benzodiazepine use
- MAOI antidepressant treatment

Please read the following and sign below:

- This patient and I would like to initiate ketamine nasal spray therapy as an adjunct to the management of the above illness
- I acknowledge that I may review information about this therapeutic option at www.tranquilmd.com and that I may contact Dr. Ashley Covington to discuss treatment
- I will follow up with this patient during and after the completion of the treatment course with Dr. Ashley Covington or refer him or her to a licensed medical professional for follow up

Physician Signature

Date

Please return the completed form:

Fax: 909-801-6996

Email: Drc@tranquilmd.com

Mail: Dr. Ashley Covington, 10323 Santa Monica Blvd Suite 101, Los Angeles, CA 90025