Confirmation of Care

At Ketamine Milwaukee we utilize a team approach and require all patients to be engaged with a mental health provider prior to starting IV ketamine infusion therapy. *Please complete this form to confirm that you are currently caring for this patient.*

Patient Name:
Date of birth:
Primary psychiatric diagnosis:
Secondary psychiatric diagnoses:

Referring Provider's Name:
Specialty:
Address:

Phone:
Fax:
Email:

Comments:
____
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____
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** Call me to discuss the patient prior to beginning ketamine treatments. **Y / N**

Provider signature: ____________________________________

Please return this form:

Via **fax** to:
Ketamine Milwaukee
(262) 208-1405

Via **US mail** to:
Ketamine Milwaukee
10424 W. Bluemound Rd.
Milwaukee, WI 53226

I can be reached by **phone** at **(414) 206-1606** to discuss your patient or ketamine therapy in general. I look forward to working with you in the care of your patient.

Kevin J. Kane, MD