CANADIAN CENTRE FOR PSYCHEDELIC HEALING

Ottawa
Thunder Bay
Sault Ste. Marie

P: (807)345-4400
F: (807)345-1133

Patient Referral Form

Physician Information			
Referring Clinician:		Phone:	Fax:
Clinician Signature:	Address:		College Number: Billing Number:
Family Physician:		Phone:	Fax:
Patient Information			
Last Name:	First:		Middle:
DOB:	PHN:		
Address:			
City:		Province:	Postal Code:
Cell Phone: (required)	Alternate Phone:	Email (required):	

Primary Indication for Referral for Ketamine-Assisted Psychotherapy

Depression ☐ PTSD ☐ OCD ☐ Substance use disorder ☐ Other ☐

Relevant clinical information:_____

_____

Additional Patient Information		
Medications tried (if known):	Medications patient is currently on:	Past medical history:
Contraindications: Uncontrolled hypertension ☐ Psychosis ☐ None ☐		

*Please fax referral when complete