AMBER KERBY
MS, LMFT
LICENSED MARRIAGE & FAMILY THERAPIST

KAP REFERRAL FORM

Client Name:_____Date of Birth:_____

Allergies:_____

Primary Care Provider/ Psychiatrist/ Mental Health Provider *(Circle One)*

Provider Address:

_____

_____

Phone Number_____Fax Number:_____

Email Address: _____

Current mental health diagnosis (with ICD-10 Code): _____

Duration of Symptoms:_____Is the current treatment refractory? YES NO

Current Symptoms:_____

_____

_____

_____

Suicidal Ideations Present? YES NO Past suicide attempt? YES NO

Is the client currently taking medications? YES NO

Current medications, dosages, and start date of therapy:

_____

_____

_____

_____

Have the medications been effective in reducing symptoms? YES NO

If the client is not currently taking medications, have they in the past? YES NO

Please list previous medications, **dates of usage, start/stop dates** which were ineffective:

1._____

2._____

3._____

Medical History including chronic illnesses, hospitalizations, and surgical history:

_____

_____

_____

_____

Any other notes about the client's history:

_____

_____

_____

_____

_____

_____

Based on my client's current diagnosis of _____,

I request that they be evaluated and, if appropriate, receive Ketamine Assisted Psychotherapy.

Referring Provider Name and Title: _____

Signature: _____Date:_____

Please return this form to KAPforms@protonmail.com