AMBER KERBY
MS, LMFT

LICENSED MARRIAGE &
FAMILY THERAPIST

KETAMINE ASSISTED PSYCHOTHERAPY (KAP) REFERRAL FORM

Name:_______________________________________Date of Birth:______________________

Allergies:____

Address:____

____

Phone Number____

Email Address: ____

I am interested in receiving KAP in a Group Format (limited to 3 people) YES NO

Current mental health diagnosis: ____

Current Symptoms:____

____

____

____

How long have you had these symptoms?____

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

Are you currently in therapy? YES NO

Name of current therapy provider:____

Provider Address:____

Phone _________________________________ Email___________________________________

Previous therapists and duration of therapy:

____

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____

KAP REFERRAL FORM Continued

Are you currently taking medications? YES NO

Current Prescriber name:____

Phone number:________________________________Email:__________________________

Current medications, dosages, and start date:

____

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____

____

Have the medications been effective in reducing symptoms? YES NO

If you are not currently taking medications, have you 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:

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I attest that all the information listed above is accurate. I am requesting an evaluation for Ketamine Assisted Therapy.

Signature: _______________________________________Date:_______________________

Please return this form to KAPforms@protonmail.com