



AMBER KERBY  
MS, LMFT

LICENSED MARRIAGE &  
FAMILY THERAPIST

### KAP REFERRAL FORM

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Phone number: \_\_\_\_\_ Email: \_\_\_\_\_

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](mailto:KAPforms@protonmail.com)**

*An email will be sent to the client and referring professional to confirm receipt*