Mind Body
WELLNESS CENTER

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COLLABORATION TO TREAT AND RELEASE MEDICAL RECORDS

RETURN TO MIND & BODY WELLNESS CENTER with copy of patient's current H&P

FAX: 402-502-3112
EMAIL: admin@MindBodyWellnessOmaha.com

_____ DOB___/_____/_____ has contacted Mind & Body Wellness Center regarding a treatment plan for a Ketamine Infusion(s) for one of the following conditions:

- ☐ Treatment Resistant Depression (TRD)
- ☐ Post Addiction Withdrawal Syndrome (PAWS)
- ☐ Suicidal Ideation**
- ☐ Single Follow-up Infusion *(This patient has undergone the protocol of 6 and is following up at least 4 weeks later)*
- ☐ Chronic Pain*
- ☐ Post Traumatic Stress Disorder (PTSD)
- ☐ Severe Anxiety
- ☐ Other: _____

The protocol calls for up to (6) forty-minute customized Ketamine IV infusions in a 2-3 week span. The patient's infusions and monitoring are conducted by a certified nurse anesthetist. During the patient's journey a guide will also be there to assist and support the needs of patient. Therapists and mental health coaches are also available should the patient desire to engage and reflect.

*Chronic pain protocol: Three IV sessions in three consecutive days. Each session lasts for approximately one hour. Starting dose is at minimum 1mg/kg up to 3mg/1kg followed by one session per week for four weeks. Finally one session per month or as needed.

** Suicidal ideations are urgent and a safe intervention should be conducted as soon as possible. The research and literature shows, after a single Ketamine infusion, suicidal ideations are far less intense.

HEALTH CARE PROVIDER INFORMATION

Provider Name: _____

Provider Phone/Fax Number: _____

Provider Address (street, City, ST, zip): _____

PATIENT: By signing below you allow the above health care provider to share medical information with Mind & Body Wellness Center

PROVIDER: By signing below A) You attest that the patient mentioned on this form does exhibit signs and symptoms OR diagnosed with condition(s) checked marked above B) You also agree the patient is in good health standing.

Patient: _____ Date: _____

Provider: _____ Date: _____

We here at Mind & Body Wellness Center want to be as comprehensive as possible. By including the patient's primary care provider and if applicable their primary mental health professional we feel the patient's best interests will be held as the primary focus. We will follow up with the patient's health care providers keeping with continuity of care. Please feel free to contact us with any questions (402) 203-5269.

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