PRESCRIPTION

KETAMINE OFFERINGS FORM

PATIENT INFORMATION

FIRST NAME: LAST NAME: DATE of BIRTH (Month / Day)

_____/_____

PRIMARY PHONE #: ◯ CELL ◯ HOME ◯ WORK SECONDARY PHONE #: ◯ CELL ◯ HOME ◯ WORK

ADDRESS: CITY, STATE, ZIP: ALLERGIES:

MEDICATIONS

☐ **Ketamine RDT*** ◯ 50mg ◯ 100mg ◯ 175mg ◯ 200mg ◯ 250mg ◯ 300mg ◯ 350mg ◯ 400mg

☐ **Ketamine Mini RDT*** ◯ 50mg ◯ 75mg ◯ 100mg

☐ **Ketamine Nasal Spray*** ◯ 10mg/ml ◯ 50mg/ml ◯ 100mg/ml ◯ 200mg/ml ◯ Custom _____mg

☐ **Ketamine Oral Capsule*** ◯ MC ◯ IR ◯ 50mg ◯ 75mg ◯ 100mg

☐ **Ketamine Injection*** ◯ 50mg/ml ◯ 100mg/ml ◯ 5ml vial ◯ 10ml vial ◯ 20ml vial

☐ Ondansetron ODT ◯ 4mg ◯ 8mg

☐ Promethazine ◯ 12.5mg ◯ 25mg ◯ 50mg

☐ Scopalamine Patch 1mg/3day ◯ #1 ◯ #4 ◯ #10 ◯ #24

☐ Sirolimus Capsule ◯ 6mg ◯ Custom _____mg

*** Ketamine** is a controlled substance either send a script or write in “KETAMINE” below.

Refills: ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ PRN ◯ NR SIG:_____

WRITE PRESCRIPTION / ADDITIONAL COMMENTS

DOCTOR PHONE NPI # DEA #

OFFICE MANAGER PHONE OFFICE FAX OFFICE Email

SIGNATURE DATE (Month / Day / Year)

_____/_____/_____