PRESCRIPTION

MENTAL HEALTH & KETAMINE 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:

RETAIL PRODUCTS (can be compounded for allergy and dose purposes)

☐ Fluoxetine ◯ Tablet ◯ Capsule	◯ 10mg ◯ 20mg ◯ 40mg ◯ 60mg ◯ 90mg
☐ Sertraline	◯ 25mg ◯ 50mg ◯ 100mg
☐ Citalopram	◯ 10mg ◯ 30mg ◯ 40mg
☐ Escitalopram	◯ 5mg ◯ 10mg ◯ 20mg
☐ Bupropion ◯ IR ◯ ER	◯ 75mg ◯ 150mg ◯ 300mg
☐ Venlafaxine ◯ IR ◯ ER	◯ 37.5mg ◯ 75mg ◯ 150mg
☐ Paroxitine ◯ IR ◯ CR	◯ 10mg ◯ 12.5mg ◯ 20mg ◯ 37.5mg ◯ 40mg
☐ Duloxetine	◯ 20mg ◯ 30mg ◯ 60mg

SUPPORT OFFERINGS

☐ Zofran Tablet ODT	◯ 4mg ◯ 8mg
☐ Phenergan	◯ 12.5mg ◯ 25mg ◯ 50mg
☐ TransdermScope 1mg/3day	◯ #4 ◯ #10 ◯ #24
☐ Sirolimus IR 6mg	

KETAMINE 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) _____/_____/_____