REQUEST FOR CONSULTATION
KETAMINE THERAPY

PATIENT INFORMATION:	Last Name:		First Name:
Date of Birth:	Age:	Address:	
City:	Prov:	PHN:	Out-of-province PHN # ☐ YES ☐ NO
Phone Number:		Email:	
Requires Interpreter ☐ YES ☐ NO	Language:		Gender M ☐ F ☐ Other ☐

REFERRING PRACTITIONER & CLINIC INFORMATION:	
☐ Family Doctor ☐ Nurse Practitioner ☐ Psychiatrist ☐ Other (Specify) :	Name: PRACID # Address: Phone: Fax:

REASON FOR REFERRAL:
Does the patient have Major Depressive Disorder that is resistant to treatment? ☐ YES ☐ NO
Any other mental health diagnosis? ☐ YES ☐ NO
If YES, please describe: ____

BACKGROUND INFORMATION:
Medical history/diagnosis:

History of alcohol/substance abuse: ☐ YES ☐ NO
If YES, please describe:

Referrer's Signature:	Date:

Please send completed form to: Manor Clinic
1107 127 Street SW Edmonton T6W 1A3 Alberta
Fax: 780-666-2608 Email: admin@manorclinic.ca
Please contact Manor Clinic on 780-669-8555 if you have any questions.

December 2021

WE WILL CONTACT YOUR PATIENT DIRECTLY

***REFERRAL LETTER WILL ALSO BE ACCEPTED IN LIEU OF MANOR CLINIC REFERRAL FORM**