HARMONY
THERAPY SERVICES

Phone: 515-981-2772 | Fax: 515-954-2771
www.harmonytherapyservices.com

KAP REFERRAL FORM – BY PROVIDER

Provider Information

Provider Name: _____

Provider Title: _____

Address:_____

_____

Phone Number: _____ Fax Number: _____

Email Address: _____

Client Information

Client Name: _____ Date of Birth: _____

Phone number: _____

Email: _____

Allergies:_____

Current mental health diagnoses (with ICD-10 Code):

_____

_____

_____

Duration of Symptoms: _____

Are symptoms unresponsive to current treatment? YES NO PARTIALLY

Current Symptoms:

_____

_____

_____

Suicidal Ideations Present? _____ YES _____ NO

Past suicide attempt? _____ YES _____ NO

Is the client currently in therapy? _____ YES* ____ NO

*Provider name (if different from referring provider): _____

Therapy Start Date: _____

Is the client currently taking medications? _____ YES* ____ NO

*Provider name (if different from referring provider): _____

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:

_____

_____

_____

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 kelsi@harmonytherapyservices.com