SOUTH SOUND HEALTH & WELLNESS CLINIC

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Acknowledgement of Ongoing Care

Patient name:		
Diagnosis/Diagnoses:		
Provider's Specialty:		
Provider's Phone Number:		
Provider's Fax Number:		
Provider's Email Address:		
Are you aware of any history of psychosis in this patient?*		
Additional comments:		
Signature of Provider:		**Date:**

You are encouraged to review information about ketamine therapy at our practice website: www.southsoundketamine.com. Our clinicians welcome any questions you may have.

*Psychosis and mania are contraindications to ketamine therapy.