Verification of Diagnosis / Confirmation of Care

This form simply acknowledges that you and the patient you name is or has been under your care. Completion of this form does NOT imply recommendation or approval of ketamine infusion therapy. Thank you for taking the time to fill out this form.

NOTE: Ketamine infusion therapy is only one part of your patient's comprehensive treatment. We require patients to maintain continuity with their referring provider following the completion of their ketamine treatments. You may review information about this therapeutic option at www.softrebootwellness.com and/or contact Dr. Herman at (650) 419-3598 to discuss the treatment protocol.

Patient Name * _____ Date of Birth * _____

Patient Phone Number * _____

Patient Email * _____

Primary Diagnosis * *Please provide ICD-10 code and date diagnosed*
(Patients with schizophrenia and/ or a current manic episode are not eligible for treatment)

Diagnosis _____ Date of Diagnosis _____

Has the patient been prescribed more than one medication or treatment for their diagnosis? *

Has the patient reported medications or treatments prescribed have been ineffective in treating symptoms? *

Current Medications *(Depression, Anxiety, Pain only please)* *

Date of Last Appointment with Patient * _____

Provider's Name * _____

Provider's Specialty * _____

Clinical synopsis, comments, reason for referral *

Provider's Email * _____

Provider's Phone * _____

Would you like Soft Reboot Wellness to contact you with patient updates? *

_____ _____

Provider's Signature * Date

Please return this form to us via our secure server by clicking the send button below. Alternatively, you may print it and then fax it to us at (650) 419-9877.