ReviveMed

Zed3 Medical Group

GP REFERRAL FORM

REVIVEMED KETAMINE INFUSION PROGRAM

Patient Details

First Name:	Surname:	DOB:
Email:	Phone number:	Address:
DVA NO:	Medicare No:	ADF DRN:

Primary Condition if known: ☐PTSD* ☐MDD* ☐GAD* ☐Substance Misuse*

Secondary Conditions if known: ☐PTSD* ☐MDD* ☐GAD* ☐Substance misuse* ☐Musculoskeletal injuries* ☐Pain* Other:

Duration of Primary Condition:

Duration of Secondary Conditions:

Background Information

Bloods
Bloods (FBC, VEC, LFT, CRP, urine) and ECG performed in the last 6 months attached ☐ YES

Preference of Service Location
☐ Canberra ☐ Wagga Wagga ☐ Adelaide

Past treatments & further comments:

☐Medication ☐Therapy

CCA Information

Referring Psychiatrist:	Provider No:	Contact number:
Email:	Address:	City/State:
Date:		

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Web: www.revivemed.com.au