Ketamine Assisted Psychotherapy Program Referral Form

Demographic Information

Patient Name		DOB	
Phone		Email	

Diagnostic History

Mental Health	
Substance Use Disorder (please note substance(s) used and if active)	
Medical	

Current Medications and Dosages (for psychiatric or other medical conditions)

Medication	Dosage	Condition		Medication	Dosage	Condition

Mental Health and Substance Use Disorder Treatment History

Type	When + Where	Outcome
TMS		
ECT		
Ketamine		
Inpatient Care		
Outpatient Care		

Current Care Providers	Name	Contact Information
Primary Care Physician		
Psychiatrist/MH prescriber		
Mental Health Therapist		
Referring Clinician		

Has your patient signed a ROI for Widening Circles staff to communicate with you? _____Yes _____No
If yes, please include it with this referral form.

Additional comments/concerns/reasons for referral:

If available, please attach any documentation you feel may be helpful (clinical summary, last treatment note, your initial assessment.) A completed referral form is required before a patient is scheduled for an assessment for our KAP program. If you have any questions regarding our KAP program, please call 828-772-1803.

Please fax the completed form to 828-378-0223; email kap@wideningcirclesnc.com; or mail to Widening Circles KAP Program, 25 Orange Street, Asheville, NC 28801.