Ventura Center for Advanced Therapeutics

FOR PROVIDERS: PATIENT REFERRAL TO DR. STEFANY WOLFSOHN AT VENTURA CENTER FOR ADVANCED THERAPEUTICS

Patient Name: _____ Date of Birth: _____
Patient Contact Information: _____ PHONE
_____ EMAIL

Reason for Referral: (check all that apply)

○ Ketamine therapy evaluation & treatment ○ IV Hydration, vitamin and supplement therapies

ICD-10 Diagnosis:

_____ _____
_____ _____
_____ _____

Reason for referral:

_____
_____
_____
_____

Referring Provider: _____
(circle one: physician, nurse practitioner, physician assistant, therapist)

Address: _____ Phone: _____
_____ Fax: _____
Email: _____

****FOR PRESCRIBERS, PLEASE FAX LAST OFFICE VISIT NOTE WITH REFERRAL FORM***

AUTHORIZATION FOR RELEASE OF INFORMATION

In the course of my examination, I, _____ herby give authorization for

Stefany D. Wolfsohn, M.D. to

☐ RELEASE MY RECORDS TO: _____

☐ OBTAIN MY RECORDS FROM: _____

_____ _____
Patient's Signature Date

PLEASE COMPLETE AND RETURN TO EMAIL OR FAX BELOW

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