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1 | Referring Therapist Information

When referring a potential KAP (ketamine assisted psychotherapy) client, please complete this Patient Information form and authorize collaboration with Pala Medicine. [Thank you - Dr. Suraiya Rahman, MD](#)

Therapist Name	Practice Name	License Type and Number
Therapist Email	Phone Number	

2 | Client/Patient Information

First Name	MI	Last Name	Date of Birth	Pronouns
Address	Unit / Apt #		Client Email	
City	State	ZIP Code	Mobile Number	

3 | Clinical Information

Primary Diagnosis	Reason for Referral to KAP? (clinical rationale for ketamine-assisted psychotherapy)
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Relevant Medical & Psychiatric History (include any known contraindications or concerns)	Current Treatment Plan (frequency of sessions, therapeutic goals, adjunctive supports)
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Current Medications	Potential KAP Treatment Plan (number of proposed sessions and approximate dates)
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Therapist Attestation

I am the treating therapist for this client/patient and have client's consent to share this information with Pala Medicine.

Signature

I believe the client/patient may benefit from KAP (ketamine-assisted psychotherapy).

Date

I am willing to collaborate with Pala Medicine to support client/patient treatment.