# Solshine Wellness Group – Clinician Referral Form

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**Referring Provider Information**

Name: _____ Office: _____ Relationship: ☐Therapist ☐PCP Other: _____

Phone: _____ Email: _____ Fax: _____

**Patient Information**

Name: _____ DOB: _____ Age: _____

***Use initials and age if submitting by email. Fax preferred if requesting us to contact patient.*

**Reason for referral:**

_____
_____
_____

**Part I: Functional & Integrative Support** (Select all that apply).

☐ Standard diagnostic work up plus optional functional medicine labs (e.g., GI panel, organic acids, pharmacogenomics, etc. as relevant).

☐ Conventional medication management (e.g., Zoloft, Abilify, Lamictal, Adderall)

☐ Deprescribing/tapering medications where safe and appropriate

☐ Nutraceutical, botanical or bioidentical hormone support (e.g., for PMS, menopause, chronic fatigue, adrenal dysfunction, etc.)

☐ IV/IM formulations to support mental and emotional wellbeing (e.g., B-vitamins, NAD+, glutathione, etc.)

**Part II: Ketamine Therapy (if applicable)**

Primary diagnosis/ symptom prompting referral: _____

Dosing type requested: ☐ Low dose (psycholytic: patient awake& engaged) ☐ Standard (psychedelic: altered state)

Used ketamine before? ☐Yes ☐No Currently taking ketamine? ☐Yes ☐No

Current dose and prescriber (if known): _____

Therapist Name: _____ Cadence of therapy planned: _____ (e.g., weekly)

KAP Trained? ☐Yes ☐No Modality used (e.g., EMDR, IFS): _____

Timing and location of therapy: ☐In person during use ☐Virtual during use ☐In person after use ☐Virtual therapy after use

**Additional Information**

☐ Patient has PCP ☐ Under care of Psychiatrist

Most recent labs (date if known): _____

Relevant medical or psychiatric history not already listed (e.g., cardiac issues, head trauma, suicidality, mania):
_____

**Scheduling Preference:**

☐ Please contact patient to schedule

☐ Patient will reach out *(If the patient does not contact us within one week, we will notify the referring provider's office)*

**Referring Provider Comments:**

_____
_____

Signature: _____ Date: _____

*This form contains PHI. You may complete and sign it digitally (Adobe Reader, Preview, DocHub) or print and fill it out by hand. Please fax to (833) 605 4406. If faxing isn't possible, email using initials and age only — we'll follow up to collect full details. Please ensure your completion and transmission methods meet HIPAA compliance requirements.*

**For Office Use Only:**

Received- Date: _____

Contacted therapist – Date/ Time: _____

Contacted Patient – Date/ Time: _____

Scheduled for -Date/ Time: _____