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## Acknowledgement of Ongoing Care Form

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<b>Patient Name:</b>			
<b>Diagnosis/Diagnoses:</b>			
<b>Provider's Specialty:</b>			
<b>Provider's Phone Number:</b>			
<b>Provider's Fax Number:</b>			
<b>Provider's Email Address:</b>			
<b>Are you aware of any history of psychosis in this patient?*</b>			
<b>Additional comments:</b>			
<b>Signature of Provider:</b>		<b>Date:</b>	

You may review information about ketamine therapy at our practice website: [www.modestoketamine.com](http://www.modestoketamine.com) Our physicians welcome any questions you have.

\*Psychosis and mania are contraindications to ketamine treatment