Carolinas Center
for Evaluation and Treatment

Provider Referral Form for
Ketamine Assisted Psychotherapy (KAP) Program

Date of Referral: _____

Referring Provider/Practice: _____

Practice Telephone #: _____

Practice Email: _____

Client Name: _____

DOB: _____

Client Telephone #: _____

Client Email: _____

Please share some basic information about your client and send the form via email to info@carolinascenter.com or fax to (704) 445-3963.
This will assist our specialists and coordinators when reaching out.
Thank you for referring to our office and we look forward to working with you!

Current Working Diagnosis(es): _____

Services Currently Receiving: _____

Current Medication Provider: _____

Known Medical Conditions: _____