DR KOBUS VAN DER WALT
Specialist General Psychiatrist

REFERRAL FORM: IV KETAMINE THERAPY SERVICE

1. Patient Information					
Full Name:				Patient Contact Number:	
Date of Birth:		Gender:		ID Number:	
Medical Aid & Number:					
Emergency Contact Person & Number:					

2. Referring Clinician Details			
Referring Clinician Name:			
Practice Number:		Discipline (e.g. Psychiatrist, GP, Psychologist):	
Practice Address:			
Contact Email:		Phone number:	

3. Primary Psychiatric Diagnosis							
	TRD (Treatment-Resistant Depression)		PTSD		Bipolar Depression		Other:

4. Indication For Ketamine Therapy - Brief Description Of Treatment History And Indication For Ketamine:

5. Screening For Contra-Indications			
	Active substance use disorder (past 6 months)		History of ketamine misuse
	History of psychosis or schizophrenia		Elevated intracranial pressure or seizure disorder
	Uncontrolled hypertension or cardiovascular disease		Severe liver or renal impairment
	Pregnancy or breastfeeding	*If any selected, elaborate:*	

	6. Current Medications - List All Psychiatric And Medical Medications (Incl. Doses):	**Dose**
1		
2		
3		
4		
5		
6		
7		

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e. reception@drkobusvanderwalt.co.za
a. Unit 105, Halo Medical Suites,
31 Gardiner Williams Avenue, Somerset West, 7130.

Sarel J Van Der Walt Inc
MB ChB, MPhil (Applied Bioethics), MMed (Psychiatry), FC Psych (SA)
Practice number: 0920797 | HPCSA: MP0643823 | Reg No: 2020/714896/21

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7. Other Psychiatric/Therapeutic Support			
Current Treating Psychiatrist:			
Contact Number:		Email:	
Psychotherapist / Psychologist (if applicable):			
Contact Number:		Email:	

8. Treatment Plan (Pre & Post-Ketamine)
Planned Psychotherapy Support (e.g. CBT, DBT, Trauma Therapy, etc.):
Planned Psychiatric Review & Medication Monitoring Post-Infusion:

9. Additional Notes / Risk Considerations
Suicide risk, comorbidities, trauma history, special care needs:

Name of Referring Clinician:

Signature of Referring Clinician:

Date:

Once completed, please submit this form to nursing@drkobusvanderwalt.co.za

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