

PROVIDER REFERRAL FORM FOR KETAMINE/SPRAVATO THERAPY

Referral to:



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Reno, Nevada 89523

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Date of Referral: _____

REFERRING PROVIDER:

Provider's Name	
Clinic Name	
Phone Number	
Fax Number	
Email	

PATIENT'S INFORMATION:

Patient's Full Name	
DOB (mm/dd/yyyy)	
Home Address	
Home Number	
Cell Number	
Email	
Insurance	
Diagnosis(es) for Referral	
Current and previous treatments for diagnosis(es) (i.e., antidepressants, augmentation therapy, other treatments)	Current: Previous:
☐ Yes ☐ No	Has the patient ever been diagnosed with bipolar or any form of psychosis?
Provider's Signature	

*** PLEASE INCLUDE CORRESPONDING SOAP NOTES AND ANY PERTINENT LABS. THANK YOU! ***