

Patient Referral for SPRAVATO[®] Treatment

ATTENTION TO:

RECEIVER FAX #:

Treatment Center Name

Phone

Fax

Email

1. PATIENT INFORMATION

First Name: _____

Last Name _____

Date of Birth: _____

Address: _____

Phone Number*: _____

Town/City: _____

State: _____

ZIP Code: _____

Email: _____

*Can a voicemail be left at this number for an appointment? Y/ N

Primary Insurance: _____

Policy #: _____

Group #: _____

Policyholder Name: _____

Card/BIN #: _____

Caregiver's Name: _____

Caregiver's Phone Number: _____

Reminder: Please fax a copy of the insurance card with this referral. Your patient may have 2 insurance cards for pharmacy and/or medical benefit.

2. MEDICAL HISTORY

Diagnosis: _____

Medical/Treatment History: _____

Medication History: _____

Additional medical reports and supporting documents are included with this form. Y/ N

3. REFERRING HEALTHCARE PROVIDER INFORMATION

Name: _____

Phone Number: _____

Practice: _____

Email: _____

Fax Number: _____

Please notify me with updates regarding my patient through: Phone/ Email/ Fax