

**REFERRAL FORM**

**DEMOGRAPHICS**

PATIENT NAME \_\_\_\_\_ DOB: \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE # \_\_\_\_\_ ALT PHONE # \_\_\_\_\_

PRIMARY INSURANCE \_\_\_\_\_ SUBSCRIBER ID \_\_\_\_\_

SECONDARY INSURANCE \_\_\_\_\_ SUBSCRIBER ID \_\_\_\_\_

Prescription Drug Insurance \_\_\_\_\_ Card BIN # \_\_\_\_\_

REFERRING PHYSICIAN \_\_\_\_\_

PHONE # \_\_\_\_\_ FAX# \_\_\_\_\_

OFFICE ADDRESS \_\_\_\_\_

**Please Designate The Services Requested For The Referral Below:**

- Medication Management
- Psychotherapy /EMDR
- Spravato (Esketamine nasal Spray)
- IV ketamine Infusion
- TMS

REASON FOR REFERRAL \_\_\_\_\_

DAIGNOSIS \_\_\_\_\_

**Medications tried in current episode: Please Send all Pertinent Medical Records**

Medication Name	Max Dose	Time period	Response/SE	Current med?

For Patient Records Applicable Under Federal Law 42 CFR Part 2 To the party receiving this information: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42) CFR Part 2 prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.



2621 Dryden Rd, Ste 100, Moraine, OH 45439  
Phone: (937) 281-0900 Fax: (937) 938-9751

List of Pre-existing Medical and Psychiatric Conditions

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Additional Information

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PROVIDER'S SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

Fax Referral at (937)938-9751

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**THIS IS NOT A REQUEST FOR MEDICAL RECORDS**