



Patient Referral for SPRAVATO® Treatment

Referring Healthcare Provider Name _____
Street Address _____
Town/City _____ State _____ ZIP Code _____
Phone _____ Fax _____
Email _____

ATTENTION TO:

RECEIVER FAX #:

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: _____

2. MEDICAL HISTORY

Diagnosis: _____

Medical/Treatment History: _____ Medications 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