



Patient Referral for SPRAVATO® Treatment

Phone: 877.385.0535

Select Treatment Location

- Kalamazoo, MI
- Grand Rapids, MI
- Carrollton, TX
- Munster, IN

ATTENTION TO:

RECEIVER FAX #:
877.326.2856

Please fax a copy (front and back) of all the patient's pharmacy and medical insurance cards as well as any relevant clinical notes/documents

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: _____

<p>Medical/Treatment History:</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Medications History:</p> <p>_____</p> <p>_____</p> <p>_____</p>
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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

Please see full Prescribing Information, including BOXED WARNINGS, and Medication Guide for SPRAVATO®.