PROVIDER REFERRAL FORM FOR KETAMINE/SPRAVATO THERAPY

Referral to:

RADIANCE
KETAMINE CLINIC

6380 Mae Anne Ave, Suite 7
Reno, Nevada 89523

T: (775) 432-1500
F: (775) 432-1002

info@RadianceKetamineClinic.com
www.RadianceKetamineClinic.com

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 CORRECESPONDING SOAP NOTES AND ANY PERTINENT LABS. THANK YOU! ***