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

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