

Select Treatment Location



Phone: 877.385.0535

Patient Referral for SPRAVATO® Treatment

ATTENTION TO: Kalamazoo, MI Grand Rapids, MI **RECEIVER FAX #:** Carrollton, TX 877.326.2856 Munster, IN **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** **PATIENT INFORMATION** Date of Birth: First Name: Last Name: 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 REFERRING HEALTHCARE PROVIDER INFORMATION Name: Phone Number: Email: Practice: Fax Number: Please notify me with updates regarding my patient through: Phone/ Email/ Fax

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