

Patient Referral for SPRAVATO[®] Treatment

Serenity Parlor
Treatment Center Name
785-840-7717 *785-706-5611*
Phone Fax
Alicia Sadler @ SerenityParlor.com
Email

ATTENTION TO:

Alicia

RECEIVER FAX #:

785-706-5611

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: _____

Reminder: Please fax a copy of the insurance card with this referral. Your patient may have 2 insurance cards for pharmacy and/or medical benefit.

2. MEDICAL HISTORY

Diagnosis: _____

Medical/Treatment History: _____ Medication 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