TRD CLINIC REFERRAL FORM

REASON FOR REFERRAL (Please circle all that apply)

TMS ECT KETAMINE SINGLE TRD EVALUATION

REFERRING CLINICIAN INFORMATION

Psychiatrist/Provider Name: ____

Office Number: ______________________________ Fax Number: ______________________________

☐ **CHECK THIS BOX IF THIS IS THE MEDICAL PROVIDER WHO WILL FOLLOW PATIENT POST TREATMENT RESISTANT DEPRESSION (TRD) EVALUATION**

PSYCHIATRIC PRESCRIBER (If other than Referring Provider)

Psychiatrist/Provider Name: ____

Office Number: ______________________________ Fax Number: ______________________________

PLEASE NOTE: ALL PATIENTS REFERRED TO THE TRD CLINIC MUST HAVE A COLLABORATING PRESCRIBER. THE TRD CLINIC PROVIDER WILL ONLY ORDER MEDICATIONS ADMINISTERED DURING CLINIC TREATMENTS.

PATIENT INFORMATION

Legal Name: ______________________________________ DOB: ______________________

Phone Number: Home: __________________________ Cell: ______________________________

Address:____

Insurance: __________________________________ ID# ______________________________

DIAGNOSIS:

All Psychiatry Comorbidities including Personality Disorder – Please Indicate Diagnosis that is Reason for Referral

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ANY SUBSTANCE USE ISSUES

____

RELEVANT MEDICAL HISTORY (Please circle all that apply)

NEUROLOGICAL RESPIRATORY CARDIAC METAL IN THE BODY

PATIENT MEDICATION HISTORY FORM			
Current Psychiatric Medications			
Medication	Dosage	Start Date	Response
Past Psychiatric Medications (include any additional on separate page)			
Medication	Last Dosage	Date Range	Reason discontinued
Allergy History (list all Allergies/Reactions):			
Have you ever had an unusual or bad reaction to local or general anesthesia?		Yes	No
Has any family member had a bad reaction to general anesthesia?		Yes	No

****** PLEASE ATTACH A LIST OF PATIENTS OTHER APPLICABLE CURRENT/PAST MEDICATIONS ******

Referring Psychiatrist Signature: _______________________________________ Date: ___________________

INSURANCE INFORMATION

PRIMARY INSURANCE

Insurance: _______________________________________ Member ID# _____________________________

Group Name: ____________________________________ Group #: _________________________________

Member Services Phone Number: ____

Precertification Phone Number (if available): ____

SECONDARY INSURANCE

Insurance: _______________________________________ Member ID# _____________________________

Group Name: ____________________________________ Group #: _________________________________

Member Services Phone Number: ____

Precertification Phone Number (if available): ____

*****Please send a copy of the Insurance cards*****

*****When Completed, please fax to 513-584-3684*****