REFERRAL FORM Date_____

Ascend Health Center
Rise above emotional and physical pain

Please send completed form to: Fax # 833-974-2062 or Email: NewPatients@AscendHealthCenter.com // Attn: New Patient Referral

REASON FOR REFERRAL: ☐ Med Management ☐Treatment Eval ☐Other _____

Patient Name_____

DOB _____ ☐ Male ☐ Female

Phone _____ ☐ Home ☐ Cell (☐ consent to text messages)

Email _____

Insurance Information: (Provide copy of Insurance Card)

Insurance: _____ Member ID: _____

Policy holders Name (if different from patient) _____

Referring Provider:

Provider _____ NPI _____

Phone # _____ Fax # _____

Diagnosis:

Treatment Resistant Depression _____ Date of Dx _____

Other Dx _____ Date of Dx _____

Medications: (Please provide updated Medication list)

PLEASE NOTE ***For Treatment Evaluation Referral- Patient must bring list of Current & Failed Medications to expediate any Prior Authorizations necessary. (**Must have at least 2 failed mediations (trial dates minimum 4 weeks) for prior authorizations)***

Is patient currently in therapy/ counseling? ☐ Yes ☐ No

If yes, Name & Number _____

Additional Notes – Such as Failed Medication Trials (include doses & dates) or Include Recent Clinical Notes, Provider Letter

_____

_____

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Please include demographic information, along with recent clinical notes or letter that can help with treatment evaluation (Ketamine, Spravato, TMS). This is necessary for any insurance authorizations.

Ascend Health Center
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