



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

*****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.***