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** ☐ **Therapy**

Patient Name_____

DOB _____ ☑ Male ☐ Female

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

Email _____

Insurance Information:

Insurance: _____ Member ID: _____

Policy holders Name (if different from patient) _____

Referring Provider:

Provider _____ NPI _____

Phone # _____ Fax # _____

Diagnosis:

Dx code _____ Date of Dx _____

Other Dx _____ Date of Dx _____

Is patient currently in therapy? ☐ Yes ☐ No

If yes, Name & Number _____

Provide a list of any Failed Medication Trials (include doses & dates) or write N/A

_____

Most Recent Clinical Notes (please attach), this information is <u>required</u> for appointments, treatments, or prescribed medications.

_____

_____

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

***PLEASE NOTE* <u>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</u>**

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