LIBERTAS MIND

NEUROHEALTH AND INFUSION CENTER

7 Southside drive, Suite 206 Clifton Park, NY 12065

Patient Referral for Treatment

IN ORDER TO REFER A PATIENT PLEASE SEND THE FOLLOWING:

1. Complete this page
2. Send a demographics sheet with insurance and contact information
3. Send your last treatment or encounter note
4. Email to info@libertasmind.com or fax to 518 - 240- 4310

1. PATIENT INFORMATION

First Name: Last Name Date of Birth

Address: Phone Number*:

Town/City: State: ZIP Code: Email:

☐ Please see attached demographics sheet showing the patient's insurance and contact information

2. MEDICAL HISTORY

Diagnosis:

Medical/Treatment History: **Medication History:**

☐ Please see last treatment or encounter note with medication list attached

Practice: Email: Fax Number:

Name: Phone Number:

Please notify me with updates regarding my patient through: Phone/ Email/ Fax

I am referring this patient for evaluation/treatment. They have a diagnosis of:

☐ Post traumatic stress disorder that is treatment resistant:

☐ Treatment resistant Depression

☐

I would like to refer my patient for consideration for the therapy listed below:

Other