



LIBERTAS MIND

Patient Referral Form

IN ORDER TO REFERR A PATIENT FOR SPRAVATO 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**

1. PATIENT INFORMATION

First Name:	Last Name:	Date of Birth:
_____	_____	_____
Address:		Phone Number*:
_____		_____
Town/City:	State:	ZIP Code:
_____	_____	_____
		Email:

2. MEDICAL HISTORY

Diagnosis:	_____
Medical/Treatment History:	Medication History:
_____	_____

Upload this form to the website or fax to 518-240-4310
Include a demographics sheet showing the patient's insurance
Attach or send the last treatment or encounter note

Practice:	Email:	Fax Number:
_____	_____	_____
Provider Name:	Provider Phone:	
_____	_____	

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

Add any additional information below:

