NeuroHealth

Provider Referral Form

Client Name:_______________________________________ **Date:** ________________

DOB: _______________ **Age:**________ **Phone:** ________________________________

Address: ____

Insurance: ____
Please include a copy of the front and back of insurance cards, if possible

Which Service/s Are You Referring The Client For?

☐ TMS ☐ Spravato ☐ Medication Management

Reason for referral, pertinent diagnosis, significant symptoms:

____

____

Medical Issues/Additional Diagnoses:

____

Current Medications:
Attaching lists is great!

____

____

Any prior substance use treatment? YES NO UNKNOWN

Goals for treatment: ____

Please send recent clinical/therapy notes, PHQ-9/GAD-7/etc., demographic information and any other pertinent information

Referring Provider Name/Credentials: ____

Address: ____

Phone: ____________________ **Fax:** _________________ **Email:** _________________
Please email the completed form and documents to info@NeuroHealthUtah.com or fax to 385-464-3155.