Spravato Referral Form

DEPRESSION HEALING CLINIC
HOPE; HEALING; FREEDOM;
CERTIFIED SPRAVATO® TREATMENT CLINIC

Date: _____

Patient Name: _____ DOB: _____

Patient Address: _____ City: _____ Zip: _____

Phone Number: _____

Spravato is indicated for use in patients who have tried and failed on at least 3 antidepressant medications.

Current Diagnosis: Major Depressive Disorder

Current Anti-Depressant Medications:

NAME	DOSAGE

Past Anti-Depressant Medications:

NAME	DOSAGE

Augmentation Medications:

NAME	DOSAGE

Referring Physician: _____

Address: _____ City: _____ Zip: _____

Phone: _____

Physician Signature: _____ Date: _____

PLEASE FAX REFERRAL TO: Depression Healing Clinic – ATTN: Courtney Sullivan, RN, BSN, CEO – 517-796-4561

ANY QUESTIONS CALL: Depression Healing Clinic 517-998-4325