HOLISTIC
WELLNESS & PSYCHIATRY

Provider Referral Form

Patient and Clinic Information:

Patient Name:_____ Date of Birth:_____ Age_____

Patient's Phone:_____ Patient's Email:_____

Allergies:_____

Primary Care / Mental Health Care Provider Name and Address:

_____

_____

_____

Phone Number:_____ Fax Number:_____

Provider's Clinical Email Address (for updates):_____

Diagnosis:

□ Major Depressive Disorder, single episode, mild (F32.0)
□ Major Depressive Disorder, single episode, moderate (F32.1)
□ Major Depressive Disorder, single episode, without psychotic features (F32.2)
□ Major Depressive Disorder, single episode, unspecified (F32.9)
□ Major Depressive Disorder, recurrent, Mild (F33.0)
□ Major Depressive Disorder, recurrent, moderate (F33.1)
□ Major Depressive Disorder, recurrent, severe without psychotic features (F33.2)
□ Major Depressive Disorder, recurrent, unspecified (F33.9)
□ Other diagnosis:
_____

Phone: 319-800-2125 or 340-244-9658 / Fax: 855-300-4759
Email: info@holisticwellness.clinic
42 7th Ave SW, Suite 100, Cedar Rapids, IA 52404
9151 Estate Thomas, Foothills Bldg, Suite 106-107, St Thomas, VI 00802

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PATIENT DEPRESSION HISTORY

Duration of Symptoms: _____ Is the depression treatment refractory? YES NO

Current Symptoms:_____

_____

_____

_____

History of or Current Substance Abuse Disorder? YES NO

If yes, list disorder and any other pertinent details (e.g. treatment course/plan, current management, length of remission, etc.):

_____

Does the patient have a history of hypertension? YES NO

If so, are they currently on medication for hypertension? Please list:_____

Most recent blood pressure:_____

Suicidal Ideations Present? YES NO

Has the patient attempted suicide in the past? YES NO

Is the patient currently taking anti-depressants or other mental health medication? YES NO

History of psychosis? (If yes, provide details): YES NO _____

(Note: Per FDA guidelines, patient must currently be taking an antidepressant to receive Spravato treatment)

Current antidepressant medications, dosages, and start date of therapy:

1. _____
2. _____
3. _____
4. _____

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Have the medications been effective in reducing depression symptoms? YES NO

If the pt. is NOT currently taking any anti-depressants, have they taken them before? YES NO

Please list previous antidepressant and antipsychotic medications, dates of usage, start/stop dates which were ineffective for treatment of depression:

1. _____ 4._____
2. _____ 5._____
3. _____ 6._____

Any other notes about the patient's history of depression:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Based on my patient's current mental health diagnosis I request that my patient be evaluated and, if appropriate, receive Spravato/Ketamine therapy.

Referring Provider Name and Title_____

Signature: _____

Date & Time: _____

Please include most recent lab work and chart notes with this form.

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