FACILITY REFERRAL

This form is to be completed by a facility personnel to make direct referrals for a patient in need of our services. We appreciate you choosing us to provide services to your patients.

[FACILITY REFERRAL] Referred by: *

- ☐ CUSD for OUTPATIENT services
- ☐ Provider Office
- ☐ Hospital
- ☐ CVS/HealthHub
- ☐ CPR
- ☐ Other

Referring Staff/Clinician Name & Contact Info: *

Simple Text

Patient Full Name *

First name | Last name

Date of Birth (MM-DD-YYYY) *

Simple Text

Email Address *

Your email

Phone Number *

Phone number

Current Home Address

Street Address | Address Line 2

State/Province/Region | Postal/Zip Code

City

PLEASE select PAYMENT option(s) [select all that applies] *

- ☐ SELF-PAY
- ☐ COMMERCIAL insurance
- ☐ MILITARY insurance [TriCare-West, TriWest (CCN)]
- ☐ MEDICARE
- ☐ MEDICAID (AHCCCS, Mercy Care)
- ☐ Other

PRIMARY Insurance (Commercial)

Simple Text

PRIMARY Insurance Claims Address

Street Address | Address Line 2

City | State/Region/Province

Postal/Zip Code

PRIMARY Insurance Claims Phone

Phone

Subscriber Name

First Name | Last Name

Subscriber Date of Birth (MM-DD-YYYY)

Simple Text

Subscriber Relationship

Select Item ▾

Member ID

Simple Text

Group Number

Simple Text

SECONDARY Insurance (Please list ALL) (If None, write "None" in section.)

Simple Text

Patient is a MINOR (<18 years old)? (BEWARE: If parents are DIVORCED or GUARDIAN, copy of legal custody documents is needed before visit is scheduled) *

- [ ] NO, I am an adult.
- [ ] YES, minor has MARRIED parents.
- [ ] YES, minor has DIVORCED parents with JOINT CUSTODY. (upload court documents)
- [ ] YES, minor has DIVORCED parent with SOLE CUSTODY. (upload court documents)
- [ ] YES, minor has GUARDIAN parents.

Patient has ACTIVE or PENDING legal case? *

- [ ] NONE. I have no active/pending legal case.
- [ ] YES. Workman Comp (explain below)
- [ ] YES. Custody Court (explain below)
- [ ] YES. Personal Injury (explain below)
- [ ] Other (explain below)

Type of Provider(s) Needed (select all that applies) *

- [ ] ADVANCED INTERVENTIONAL TREATMENT [TMS, MeRT, Spravato, Ketamine, Photobiomodulation]
- [ ] PSYCHIATRY [medication management]
- [ ] COUNSELING [talk therapy]

****COUPLES/MARRIAGE/FAMILY THERAPY: Who will accept responsibility as the "chart holder" of records?**

Simple Text

****COUPLES/MARRIAGE/FAMILY THERAPY: Who will accept financial responsibility?**

Simple Text

Reason(s) for Appointment [select ALL that applies] *

- ☐ Medication Treatment
- ☐ TMS/MeRT for Depression, Anxiety, PTSD, TBI
- ☐ TMS/MeRT for Autism (ASD)
- ☐ TMS for OCD
- ☐ Spravato (esketamine) for Depression
- ☐ Spravato (esketamine) for Suicidal Ideation
- ☐ Ketamine Infusion (IV)
- ☐ Nutrition Infusion (IV)
- ☐ ADHD diagnosis & treatment
- ☐ Individual talk therapy
- ☐ Marriage/Couples talk therapy
- ☐ Family talk therapy
- ☐ PTSD/Trauma talk therapy - EMDR
- ☐ PTSD/Trauma talk therapy - ART
- ☐ Treatment Solutions for Veterans
- ☐ Autism (ASD)
- ☐ Concussion/TBI
- ☐ Depression
- ☐ Anxiety
- ☐ Grief
- ☐ Postpartum depression
- ☐ Psychosis
- ☐ Personality Disorder (ie. Borderline)
- ☐ Behavioral/School Issues
- ☐ Foster/Adoption Support
- ☐ Recent Suicidal Ideation
- ☐ OTHER (comment below)

Patient is in ACTIVE treatment for SUBSTANCE ABUSE? (select ONE) *

- ☐ YES, currently in INPATIENT detox treatment program
- ☐ YES, currently in OUTPATIENT substance treatment program (MAT, substance IOP, treatment with Methadone or Suboxone or Subutex)
- ☐ NO, discharged from detox program LESS THAN 30 days
- ☐ NO, discharged from detox program MORE THAN 6 months
- ☐ NO, NEVER undergone, referred for, or refused detox treatment for substance abuse
- ☐ UNKNOWN

Patient is ACTIVELY using the following substance(s) WITHOUT a prescription. (select ALL that applies) *

- ☐ NONE
- ☐ Alcohol (daily use)
- ☐ Marijuana
- ☐ Ecstasy, MDMA
- ☐ Methadone, Amphetamine
- ☐ Cocaine, Heroin, Crack, LSD, Hallucinagens
- ☐ Opioids (Fentanyl, Morphine, Oxycodone (Percocet), Dilaudid, etc)
- ☐ Benzodiazepine (Xanax, Valium, Ativan, Klonipin, Tamazepam) (please list amount in comment below)
- ☐ OTHER (comment below)
- ☐ UNKOWN

Patient interested in ADVANCED treatment(s).

- ☐ TMS (Transcranial Magnetic Stimulation)
- ☐ Advanced EEG-Guided TMS (MeRT)
- ☐ Spravato (esketamine)
- ☐ Ketamine IV Infusion
- ☐ Photobiomodulation (Titan IR)
- ☐ None

<> Patient has been DIAGNOSED with?

- ☐ Severe Depression (MDD)
- ☐ Severe Depression (MDD) with Anxiety
- ☐ Severe Depression (MDD) with Recent Suicidal Thoughts
- ☐ Generalized Anxiety Disorder (GAD)
- ☐ Bipolar I/II Disorder (BP)
- ☐ Obsessive Compulsive Disorder (OCD)
- ☐ Posttraumatic Stress Disorder (PTSD)
- ☐ Concussion/TBI/Brain Injury
- ☐ Postpartum Depression (PPD)
- ☐ Autism (ASD)
- ☐ Other
- ☐ None of the above

<> Patient has tried ANTIDEPRESSANT medications?

- ☐ 0 antidepressant medication
- ☐ 1-2 antidepressant medications
- ☐ 3-4+ antidepressant medications

<> Patient has tried following ADVANCED treatment(s)?

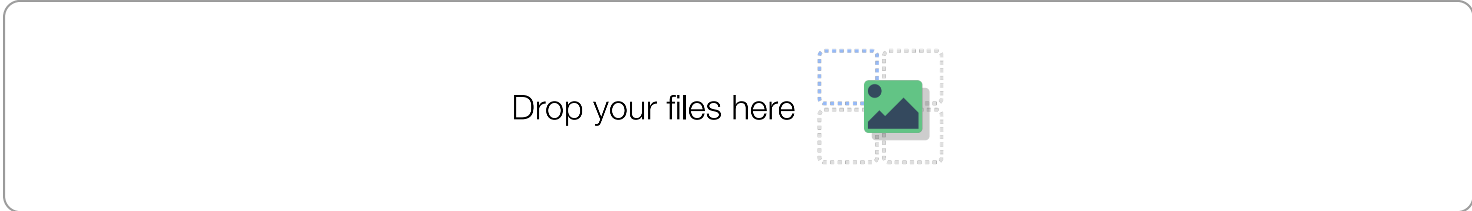
- ☐ YES. TMS helped my symptoms.
- ☐ YES. ECT helped my symptoms.
- ☐ YES. Spravato helped my symptoms.
- ☐ YES. IV Ketamine helped my symptoms.
- ☐ NO, but I want to learn more about these treatments.
- ☐ NO, I am not interested.

<> Any presence of non-removable metal in head?

- ☐ NONE
- ☐ Metal fragments
- ☐ Aneurysm clips
- ☐ Skull plates
- ☐ Cochlear implant
- ☐ Deep brain stimulator implant
- ☐ Vagal nerve stimulator implant

Additional Information (Please provide brief description of your needs, situation or any information to clarify questions above) *

Upload the following: (1) insurance card (FRONT & BACK), (2) photo ID (FRONT & BACK), (3) court custody documents, and (4) any other supporting materials (30MB file size limit)



Submit Now