SPRAVATO REFERRAL FORM

Send completed form to:

Email: patients@matthewbergermd.com | **Fax: (570) 207-0615**

Offices of Psychiatry & Counseling Services
Matthew A. Berger, MD, PC

REFERRAL SOURCE INFORMATION

Provider: | NPI: | Phone: | Fax:

Practice: | Address: | Email:

PATIENT INFORMATION

Patient: | Age: | DOB: MM DD YYYY

Address: | Phone:

Gender: ☐ Female ☐ Male **INSURANCE:** Primary: | Secondary:

Current diagnosis code:

Current medications:

HISTORY QUESTIONS

Are you diagnosed with Major Depressive Disorder, moderate or severe? ☐ Yes ☐ No

Other diagnosis:

Are you currently taking an antidepressant? ☐ Yes ☐ No

Name/dose:

ALL other psychotropic medications tried (name/doses/results):

Who is your current prescriber?

Psychiatrist: | Therapist:

PAST ALTERNATIVE TRIALS / OTHER TREATMENTS FOR DEPRESSION

☐ TMS Date: MM DD YYYY

Results:

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PAST TREATMENTS (CONTINUED)

☐ ECT Date: MM DD YYYY

Results:

☐ Ketamine Date: MM DD YYYY

Indication:

Results:

Other:

PCP, PREGNANCY & SUBSTANCE USE

Who is your PCP and will you consent to communication with PCP for medical clearance?

☐ Yes ☐ No Name:

Address: Phone:

Currently pregnant and/or breastfeeding? ☐ Yes ☐ No

Name: Phone:

Address:

Any current or previous substance use? ☐ Yes ☐ No

Substance used: Last use: MM DD YYYY

Rehab/MAT:

SCREENING QUESTIONS

Please check any of the following (check all that apply):

☐ Hepatic disease ☐ Seizure disorder ☐ Cardiac disease/HTN

☐ Substance abuse ☐ Family hx of substance abuse ☐ Aneurysmal disease

☐ Head injury/Brain bleed

The above comorbid conditions are controlled with or without medication(s):

☐ Yes ☐ No ☐ N/A Name of medication:

Do you have reliable transportation to and from treatment facility? ☐ Yes ☐ No

Name/relationship of person:

Has the member used any substances in the last 30 days? ☐ Yes ☐ No

Describe: Date: MM DD YYYY