



Patient Referral for SPRAVATO® Treatment

PLEASE FAX COMPLETED FORM TO: 256-666-9540

Treatment Center Contact Name: Theresa Campbell Date: _____
 Street Address: 929 Willowbrook Dr. SE Hsu AL 35802
 Phone: 256-489-0757 Fax: 256-666-9540 Email: info@stlukeinc.com

1. PATIENT INFORMATION

First Name: _____ Last Name: _____ Date of Birth: _____
 Address: _____ Phone Number*: _____
 Town/City: _____ State: _____ ZIP Code: _____ Email: _____
 *Can a voicemail be left at this number for an appointment? Y/ N
 Primary Insurance: _____ Policy #: _____ Group #: _____
 Policyholder Name: _____ Card/BIN #: _____
 Caregiver's Name: _____ Caregiver's Phone Number: _____

2. MEDICAL HISTORY

Diagnosis: _____
 Medical/Treatment History: _____ Medications History: _____
 Additional medical reports and supporting documents are included with this form. Y/ N
 Patient Signature for ROI (release of information): _____

3. REFERRING HEALTHCARE PROVIDER INFORMATION

Name: _____ Phone Number: _____
 Practice: _____ Email: _____ Fax Number: _____

- Once we receive all the necessary documents, we may take steps to:
- Contact your patient to schedule a consultation, where we will discuss treatment, answer preliminary questions, and collect any additional information needed
 - Gather and submit documentation for prior authorization with insurance
 - Complete a benefits investigation and notify the patient of any anticipated out-of-pocket costs
 - Update you on your patient's treatment response and progress

Our experienced and caring staff look forward to treating your patient!
 Your patient may continue to see you for their general care. If you feel that your patient would benefit from seeing one of our clinicians for general care, please call us at the phone number given above to speak with our patient coordinator.

4. FAX INSTRUCTION

Send completed form to our fax number: _____

Please see accompanying full Prescribing Information, including BOXED WARNINGS, and Medication Guide for SPRAVATO®.