Spravato® (esketamine) Referral Form

Practice Information

Practice Name: _____
Fax: _____ **Phone:** _____
Email (secure): _____
Address: _____

Patient Information

Patient Name: _____
Date of Birth: ____ / ____ / _____
Preferred Name: _____
Pronouns: _____

Phone: _____ **Email:** _____
Address: _____

☐ Patient is aware of and consents to this referral
☐ Patient prefers to be contacted directly by the psychiatry practice

Insurance Information

Insurance Carrier: _____
Member ID: _____
Group Number: _____

☐ Self-Pay / Out-of-Pocket
☐ Insurance verification pending
☐ Insurance not accepted by psychiatry practice (patient aware)

Referring Provider Information

Referring Provider Name: _____
Credentials: _____
Practice / Organization: _____

Phone: _____ **Fax:** _____
Email: _____

Clinical Information (Minimum Necessary)

Presenting concerns / symptoms:

Current psychiatric diagnoses (if known):

Current psychiatric medications & doses:

Safety Considerations:

History of substance use disorder: ☐ No ☐ Yes (details): _____
Any contraindications to esketamine therapy: ☐ No ☐ Yes (details): _____
Recent lab work or relevant imaging: ☐ No ☐ Yes (details): _____

Safety considerations:
☐ No known safety concerns
☐ History of suicidal ideation
☐ History of suicide attempt
☐ History of violence toward others
☐ Other: _____

Urgency of Referral

☐ Routine
☐ Semi-Urgent (within 2–4 weeks)
☐ Urgent (within 72 hours)
☐ Crisis — *patient directed to emergency services*

This referral does not substitute for emergency evaluation.
If the patient is in crisis, they have been instructed to call 988 or go to the nearest emergency department.

Records Included

☐ Medication list
☐ Recent progress notes
☐ Labs
☐ Discharge summary
☐ Psychological testing
☐ Other: _____

Authorization & Acknowledgments

By submitting this referral, the referring provider affirms that the above information is accurate to the best of their knowledge and shared in accordance with HIPAA's **minimum necessary** standard.

This referral does not guarantee acceptance into care.
Acceptance is contingent upon clinical appropriateness, capacity, licensure, and insur ance considerations. Please fax to 360-209-8565.

Referring Provider Signature: _____
Date: ____ / ____ / _____

Optional Footer Language (Recommended)

This form contains protected health information intended solely for treatment coordination. If received in error, please notify the sender and securely destroy the document.