PRECISE
CLINICAL NEUROSCIENCE SPECIALISTS

Spravato® (esketamine) CIII
28 mg nasal spray

Spravato Referral Form

Contact Person: Mandeep Kaur

Covered diagnosis for Spravato Treatment:

- Treatment Resistant Depression
- Depressive Symptoms in Adults with MDD with Acute Suicidal Ideations or Behavior

Treatment Requirement:

- Patient able to bring a driver to each treatment appointment: Y or N
- Patient able to stay in office for 2 hours for each treatment twice a week: Y or N

Patient Information:

Name: _____ **DOB:** _____

Phone: _____ **Alt Phone:** _____

Email: _____ **May we leave a voicemail:** Y or N

Address: _____ **City/Zip:** _____

Primary Insurance: _____ **SSN:** _____

Policy Holder's Name: _____ **DOB:** _____

Policy Number: _____ **Ins Phone:** _____

Secondary Insurance: _____ **Policy Holder:** _____

Policy Holder's Name: _____ **DOB:** _____

Policy Number: _____ **Ins Phone:** _____

Current Medications: Please list all current medications patient is taking

_____

_____

Tried and Failed antidepressants in the past:

_____

_____

Any other Medical/Health History:

_____

_____

3531 Lakeland Drive Suite 1060 Flowood MS 39232 P: (601) 420-5810 F: (601) 420-5811
230 Trace Colony Park Drive Ste 4, Ridgeland, MS 39157 www.precise-mind.com

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Referring Physician Information:

Provider Name: _____ Office Contact Name: _____

Phone Number: _____ Fax: _____

Please Include with this form:

- copy of insurance cards front and back
- Last office notes with diagnosis including approximate date of diagnosis and medication list
- Signed medical release from a patient so we can communicate about patient in future

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