Evolve Health

Referral Form

16100 NW Cornell Rd, Suite 190
Beaverton, OR 97006
P: 971.405.5960
F: 971.405.5961

2255 NW Shevlin Park Rd, Suite 110
Bend, OR 97703
P: 541.728.2525
F: 503.917.4971

8285 West Arby Ave, Suite 200
Las Vegas, NV 89113
P: 725.212.4523
F: 725.212.4524

6400 SE Lake Rd, Suite 155
Portland, OR 97222
P: 503. 447.3285
F: 503.917.4971

Patient Information Date _____

Name _____ DOB _____ Phone _____
May attach face sheet

Address _____

_____

Email _____

Insurance _____

Referral for Treatment with: Please check all that apply

☐ **Evaluate & Treat** ☐ **SPRAVATO™** (esketamine) Nasal Spray

☐ **TMS** ☐ **Ketamine IV/IM**

Request Type

☐ **Standard:** Major Depressive Disorder, recurrent moderate to severe

☐ **Expedited**: Major Depressive Disorder with acute Suicidal Ideation or Behavior
Please call the clinic if referring a patient for expedited treatment.

Clinical Information Please attach pertinent clinical notes and information for this patient.

Diagnosis with ICD-10 _____

Please attach the following if any on file:

- Current PHQ-9, HAM-D, QIDS-SR, or MADRS Depression Scale Score
- Summary of patient's treatment history and medication list

Additional Requests or Concerns _____

_____

How would you prefer to receive updates on your patient's progress?

☐ Email ☐ Phone ☐ Fax

Referring Organization _____

Referring Provider Name (please print) _____

Provider Signature _____