



lifeline interventional therapeutics
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Spravato® Consultation Referral Form

Treatment Resistant Depression

Referring Provider:

Provider Name: _____ Office: _____

Phone: _____ Email: _____

Fax: _____

Address: _____

Patient Information:

Name: _____ Date of Birth: _____

Phone: _____ Email: _____

Address: _____

Reason for Referral: _____

If your patient suffers from Treatment Resistant Depression (TRD), and you believe they would benefit from Spravato® treatment, complete this form and return to
fax# 616-360-2034.