Patient Referral Form

6548 S. McCarran Blvd.
Suite A
Reno, NV 89509

775-336-1256 (P)
775-336-6410 (F)
intake@thunderpain.com

Date ____________

Name ____________

DOB ____________ Insurance ____________

Address ____________

City ____________ Zip ____________

Phone ____________ Email ____________

REFERRAL FOR TREATMENT (check all that apply)

- ◯ **Evaluate and Treat**
- ◯ **SPRAVATO (esketamine) Nasal Spray**
- ◯ **TMS**
- ◯ **IV Ketamine -- Pain**
- ◯ **IV Ketamine -- Depression**
- ◯ **Other** ____________

REQUEST TYPE -- *Please call the clinic if referring a patient for urgent treatment*

- ◯ **Standard:** appointment within 2-4 weeks
- ◯ **Urgent:** appointment within 1 week

CLINICAL INFORMATION

Please attach pertinent clinical notes and information, including:

- Current PHQ-9, HAM-D, or MADRS Depression Scale Score
- Summary of patient's history of psychotherapy
- Medication list

ICD-10:

- ◯ F32.2 - MDD, severe, single episode
- ◯ F33.2 - MDD, severe, recurrent
- ◯ G89.4 - chronic pain syndrome
- ◯ Other ____________

ADDITIONAL REQUESTS OR CONCERNS: ____________

____

Referring Organization ____________

Referring Provider Name (PRINT) ____________

Signature ____________

Contact Preference

- ◯ Email
- ◯ Phone
- ◯ Fax