wellbeing

PATIENT REFERRAL FORM

Patient Name _____ Date _____

Patient DOB _____ Patient Phone # _____

Patient Address _____

Medical Diagnosis (with corresponding ICD codes):

Current Medications and Dosages (psychiatric and medical):

Reason for Referral:

If known, please note any positive history of the conditions below:

Substance use disorder. Please note substances and date: ☐ Yes ☐ No

1076 S Gaylord St Denver, CO 80209
(303) 722-0367

History of treatment with ECT, TMS, or ketamine: ☐ Yes ☐ No

Referring/Collaborating Clinician: _____

Address: _____

Phone: _____ Fax: _____

Email: _____

Please include any documentation that you feel may be helpful (i.e., H&P, progress notes, etc.).

Please email this completed form to team@thewellbeingcompany.com.

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