VICTORY CLINIC

victoryclinics.com

Patient Referral Form for Victory Clinic TMS & SPRAVATO® Treatment Centers

Please send completed form to: FAX 877-808-1658 or EMAIL intake@victoryclinics.com

Which Victory Clinic location does patient prefer? _____

1. PATIENT INFORMATION

Name (last, first): _____

Street Address: _____

City, State, Zip Code: _____

Phone number: _____ Is this a mobile number? ☐ Yes ☐ No

Can a voicemail be left at this number? ☐ Yes ☐ No

Date of birth: _____

Primary Insurance: _____

Insurance Number: _____

Policyholder Name: _____

Policyholder DOB: _____

2. MEDICAL HISTORY

Reason for referral: _____

Please answer the following, if known (optional)

Has patient now or in the past had therapy? ☐ **Yes** ☐ **No**

Type of therapy and duration? _____

Diagnoses related to mental health: _____

Medications (current or past for mental health conditions and duration):

_____

Has patient had genetic testing for medication metabolism? ☐ Yes ☐ No

Has patient had any neuropsychology testing? ☐ Yes ☐ No

Has patient received TMS previously? ☐ Yes ☐ No

Has patient received ketamine or SPRAVATO® previously? ☐ Yes ☐ No

Does patient have seizures? ☐ Yes ☐ No

Does patient have any metal implants or devices? ☐ Yes ☐ No

Does patient have a history or family history of aneurysm, brain bleed, or any other arteriovenous malformation? ☐ Yes ☐ No.

3. REFERRING HEALTHCARE PROVIDER INFORMATION

Name and credentials: _____

Practice: _____

Street Address: _____

City, State, Zip Code: _____

Phone: _____

Fax: _____

Email: _____

Thank you for your referral and for trusting us with your patient's/client's care. We will reach out to schedule a new patient phone intake soon. Let us know if you have any questions or concerns. –The Team at Victory Clinic

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