



Referral Form – Outpatient Psychiatric Services

(Medication Management, TMS, and Spravato®)

Return by fax: (720) 306-5382, or email: Inquiries@PsycheDenver.com

Patient Information

Last Name

First Name

Middle Initial

Birth Date mm/dd/yy

Age

Gender

- Male Female
Non-binary

Address

City

State

Zip

Best Contact Phone Number

Messages OK?

- Text Voice

Email Address

Emergency Contact

Name

Relation to Client

Best Contact Phone Number

Referring Clinician Information

First Name

Last Name

Practice/Clinic

Phone

Fax

Email

Referral Type

Referral Type (check all that apply):

- Outpatient Psychiatric Medication Management
- Transcranial Magnetic Stimulation (TMS)
- Spravato® (esketamine) treatment
- I'm unsure

Any other notes about why patient is being referred?

Clinical Information

Primary Diagnosis

Secondary/Relevant Diagnoses

Current Medications

Past Psychiatric Treatments/Trials

Therapy Medications TMS ECT Other Other. Please describe.

Allergies?

Please list any known allergies.

Relevant Medical History

Please list any known allergies.

Supporting Documentation (Including other documents? Please describe below.):

Describe Attachment1

Describe Attachment2

Describe Attachment3

Please upload the following types of documentation: Recent psychiatric/medical notes, Medication history, Labs, Insurance information

Acceptance & Signature

At Psyche PC, our goal is to work in partnership with you to support your patient's mental health needs. We evaluate each patient independently and recommend treatment options that are clinically appropriate and in the patient's best interest—while always respecting your ongoing relationship with them. We maintain open communication, keep you updated throughout the course of care, and return the patient to your primary management once psychiatric treatment is complete. Our team values collaborative care and strives to

complement the important work you're already doing.

⚠ Note: Completion of this form does not guarantee acceptance into treatment programs. Patients may require additional assessment to determine eligibility (especially for TMS and Spravato®).

My signature confirms that the information provided above is accurate to the best of my knowledge and may be used by Psyche PC to evaluate and contact the patient for psychiatric services. Digital signature accepted — typing your name is fine.

Signature Date

Thank you for the referral!

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