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Referring Psychologist / Clinic Information:  Clinic Name:  Office Phone #:  Office Fax #:  Referring Psychologist:  Prac ID:  Signature:  Electronic Signature Disclaimer: By signing your name electronically on this referral form, you are agreeing that your electronic signature is the legal equivalent of your manual signature on this form.	Patient Information:  Last Name:  First Name:  Address:  Gender:
Service offerings included in referral:  Initial Consultation  Ketamine-Assisted Therapy  Repetitive Transcranial Magnetic Stimulation  Other Psychedelic-Assisted Therapies  General Therapy	Diagnosis:  ☐ MDD ☐ PTSD / cPTSD ☐ Anxiety ☐ Addiction ☐ Bipolar Affective Disorder
Reason for Referral or Diagnosis:  Other Specialists Involved in Care:	
Relevant Past (Mental Health History):	