Atrium Health External
Interventional and Neurocognitive Psychiatry
Consultation Referral
fax to 704-446-7393

PLEASE INCLUDE A COPY OF PATIENT'S INSURANCE CARD OR FACESHEET WITH INSURANCE INFORMATION

Date of referral_________________.

IMPORTANT: To proceed with your referral, we must have patient's insurance information as Atrium Health facilities may be out of network. Please fax a copy of patient's insurance card or send copy of face sheet with insurance information to fax 704-446-7393. Once we receive your referral and verify insurance benefits, we will contact your patient to schedule a consultation or inform you if we are unable to schedule a consultation for any reason.

Patient Name:	Patient Date of Birth:

Patient contact number:	Interventional Psychiatry treatment you wish considered for your patient: ☐ECT only ☐ TMS only ☐ Esketamine (Spravato) therapy only ☐ Our recommendation based on this consultation
Diagnoses:	

Note: For TMS insurance eligibility, please document at least 4 antidepressant medication trials during the **current episode.**

Antidepressant Medication tried during the current episode	Check if patient currently taking	Duration	Maximum Dose tried	Augmentation Agent used with this medication	Check if patient currently taking	Response (pos. and/or neg – list any rating scales used, such as PHQ-9, GAD-7, BDI)
1.						
2.						
3.						
4.						

Other Psychiatric Medications tried during current episode	Check if current patient currently taking	Maximum Dose tried	Duration	Response (positive and/or negative – indicate any objective measures used, such as PHQ-9, GAD-7, BDI)
Psychotherapy (Specify Type of Therapy i.e. CBT, DBT, PHP)		Session Frequency	Duration in Therapy	Response (positive and/or negative – indicate any objective measures used, such as PHQ-9, GAD-7, BDI)

Other past Psychotropic medication trials tried

Additional Medical History	
Does patient have any metal in his/her body?	YES, where________________________ NO
Cardiovascular or Neurological conditions?	Please Specify

Psychiatric Hospitalizations		
Hospital	When?	Reason?
Partial Hospitalization Program	When?	Reason?

Past Treatment	When	Where	Treatment Parameters	Response
TMS				
ECT				
Other				

Currently Prescribed Non-Psychiatric Medications		
Medication	Dose	Frequency
Please List current PCP:	**Name:**	**Phone:**

Please attach additional medication sheet if needed

Referring Practitioner: ***Must be signed by a Physician, PA, or NP***		
Name (Print):	Signature:	
Date:	Phone:	Fax:

Note: Atrium Health Interventional Psychiatry functions as a consultation service. All primary psychiatric needs remain with the referring practitioner during and after any Atrium Health Interventional Psychiatry treatment.

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