RISE INTEGRATED MENTAL HEALTH

Clinician Referral Form

Patient Name: _____Date: _____

Patient DOB: _____ Patient Phone: _____

Patient Email: _____

Patient Physical Address: _____

Insurance: _____

Diagnosis(es) and Reason for Referral:

Potential Services for Patient:

- ☐ Neurotherapeutics (TMS, Esketamine/Spravato, IV Ketamine)
- ☐ Medication Management
- ☐ Group or Individual Therapy
- ☐ Intensive Outpatient Program (IOP)
- ☐ Women's Mental Health Consult
- ☐ WAVE Program, Group, & RN Coaching

Medical Conditions:

Current Medications and Doses:

Past Medication Trials: Please provide dosages, duration and efficacy of drug trials if applicable:

Physician/Provider Name: _____

Address:_____

Phone: _____ Fax: _____

Email: _____

For a list of other outpatient programs or with any questions regarding our services, please call 207.630.2922. Please fax the completed form to 207.805.7970, email to referrals@riseimh.com, or mail to 4 Market Place Drive, Ste 1-2, York, ME 03909. For an electronic version of this form, please visit www.riseimh.com/referral-form