The Wellness Collective
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Spravato® (Esketamine) Treatment Referral Form

Referring Clinic Information

Referring Clinic: _____ Referring Provider: _____

Address: _____

Phone: _____ Email: _____

Patient Information

Full Name: _____ Date of Birth: _____

Address: _____

Phone: _____ Email: _____

Insurance Provider: _____ Policy #: _____

Patient Medical Information

Current medications and doses:

_____

Allergies: _____

Reason for referral:

_____

Diagnosis (ICD-10 Codes)

- ☐ F32.2 Major Depressive Disorder, Single Episode, Severe
- ☐ F33.2 Major Depressive Disorder, Recurrent, Severe
- ☐ F32.1 Major Depressive Disorder, Single Episode, Moderate
- ☐ F33.1 Major Depressive Disorder, Recurrent, Moderate
- ☐ Other (specify below)

_____

Requested Services at New Clinic

- ☐ Spravato evaluation and ongoing treatment
- ☐ Medication management
- ☐ Continuation of existing Spravato treatment
- ☐ Coordination of care with referring provider

Supporting Documentation (attach if available)

- ☐ Medication list
- ☐ Prior authorization (if applicable)
- ☐ Office visit notes

Please fax completed form to 319-249-2807 or email to info@iawellnesscollective.com.
For questions, call The Wellness Collective at 319-775-0727. www.iawellnesscollective.com