LENOX HILL
MIND CARE

Provider Referral Form

Patient Information

Name:

DOB:

Phone:

Primary Diagnosis:

Provider Information

Referring Provider Name:

Specialty:

Provider's Email:

Provider's Phone:

Provider's Fax:

Reason for Referral:

Psychiatric History (*hospitalization, current illness, previous treatments e.g. TMS, ECT, prior ketamine*):

Previous Psychiatric Medication Trials:

Please complete and return form via fax: 212-717-4872 or e-mail: info@lenoxhillmindcare.com