SANA

Psychiatric Associates

SANA Psychiatric Associates - Referral Form

Fax: (214) 308-2719

Referring Provider Information

Provider Name:	Practice Name:
Phone Number:	Fax Number:
Email Address:	

Patient Information

Patient Name:	DOB:
Phone Number:	Email:
Insurance Provider:	Policy Number:

Note:

If easier, you may attach a copy of the patient's insurance card instead of filling out the insurance fields above.

Referral Reason(s)

☐ Psychiatric Evaluation / Diagnostic Assessment	☐ General Psychiatry Care
☐ Medication Management / Adjustment	☐ Transcranial Magnetic Stimulation (TMS)
☐ Spravato® (esketamine) Treatment	☐ Other: _____

Additional Notes:

_____

_____

_____

Fax to: (214) 308-2719 or Email: info@sanapsychiatric.com

Thank you for your referral. We will contact the patient promptly to schedule.