



Patient Referral for Spravato® or Ketamine Treatment

Patient Information

First Name:

Last Name:

Date of Birth:

Street Address:

Phone Number:

City:

State:

Zip code:

Email:

Can a voicemail be left at this number? Yes No

Primary Insurance:

Policy Number:

Group Number

Policy Holder Name:

Customer Service #

Referring Healthcare Provider Information

Name:

Phone Number:

Practice:

Email:

Fax Number:

Healthcare Referring Provider Contact Preference: Patient directly Provider first

Please submit form via fax or email and our Andala Patient Services will respond within the next 24 hours.

Signature

Date

CONTACT US

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