



REFERRAL FORM

Integrated Psychiatry & Wellness Services

7400 E Orchard Rd, Suite 3030N | Greenwood Village, CO 80111

P 720-719-6887 | F 833-468-5314 | mgiron@transcendfunctionalhealth.com

Please complete the relevant sections and fax the referral with supporting clinical records and insurance information.

1. SERVICE REQUESTED	
☐ Deep TMS Evaluation	☐ Spravato (esketamine) Evaluation
☐ Medication Management	☐ Photobiomodulation / Red Light Therapy
2. PATIENT & INSURANCE INFORMATION	
Patient Full Name	Date of Birth
Preferred Phone	Email
Address	City / State / ZIP
Primary Insurance	Member / Policy ID
Group Number	Policyholder Name
Secondary Insurance (if applicable)	Secondary Member ID
3. REASON FOR REFERRAL / DIAGNOSIS	
☐ Treatment-Resistant Depression ☐ Major Depressive Disorder ☐ Anxiety ☐ PTSD / Trauma Symptoms ☐ Mood Disorder	
☐ Sleep Disturbance ☐ Cognitive Symptoms / Brain Fog ☐ Chronic Pain Support ☐ Cancer Survivorship Support ☐ Other: _____	
Primary diagnosis / ICD-10 (if known): _____	
Brief clinical reason for referral / treatment goals: _____	
4. CLINICAL & TREATMENT HISTORY	
Current medications (include dose if available)	Prior psychiatric medications / treatment trials
_____	_____

Relevant history / safety information (check if known): ☐ Psychiatric hospitalization ☐ Substance use history ☐ Seizure history ☐ Significant cardiovascular / neurologic history ☐ Pregnancy / breastfeeding ☐ None known



REFERRAL FORM - CLINICAL DETAILS

5. SERVICE-SPECIFIC NOTES

Deep TMS: prior treatment response, psychotherapy history, or other relevant notes

Spravato: diagnosis, prior antidepressant trials, and other relevant treatment history

Medication Management: current concerns, recent medication changes, or consultation question

Photobiomodulation: indication / wellness goal and relevant medical history

6. DOCUMENTS INCLUDED

- ☐ Insurance card(s) ☐ Medication list ☐ Recent progress note ☐ Psychiatric evaluation
- ☐ Prior medication / treatment history ☐ Relevant labs / medical records ☐ Other supporting records

Spravato referrals: Please include supporting diagnosis and treatment history when available. Spravato is administered in a certified healthcare setting and requires post-dose monitoring.

7. REFERRING PROVIDER INFORMATION

Referring Provider Name / Credentials	Practice / Organization
Phone	Fax
Email	Preferred update method: ☐ Phone ☐ Email ☐ Fax

Provider comments / care-coordination requests:

8. PROVIDER ATTESTATION

Provider Signature	Date
Printed Name / Credentials	NPI (optional)

FAX COMPLETED REFERRAL TO 833-468-5314 | Questions: 720-719-6887

Transcend Functional Health | 7400 E Orchard Rd, Suite 3030N, Greenwood Village, CO 80111