



PROVIDER REFERRAL FORM

Please fill out the information below and fax this form to 719.623.0165.

Referring Provider:	
Provider Email:	Date:
Clinic Name:	Clinic Location:
Clinic Phone Number:	Fax Number:

Patient Name:		Date of Birth:
Street Address:		
City:	State:	Zip Code:
Phone Number:	Insurance Carrier:	
Is the patient an Active-Duty Service Member? Y: <input type="checkbox"/> N: <input type="checkbox"/> Unsure: <input type="checkbox"/>		
Which services would you like your patient to receive?		
Therapy: <input type="checkbox"/> Medication Management: <input type="checkbox"/> Transcranial Magnetic Stimulation (TMS): <input type="checkbox"/>		
If checked "YES" for TMS Services:		
Has the patient been on at least 2 antidepressant meds? Y: <input type="checkbox"/> N: <input type="checkbox"/> Unsure: <input type="checkbox"/>		
Has the patient been involved with talk therapy? Y: <input type="checkbox"/> N: <input type="checkbox"/> Unsure: <input type="checkbox"/>		

fccwellbeing.com

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