Shifa Health

REFERRAL FORM

Please send the last chart note, including all current medications, any past psychiatric medications tried that your office knows about, along with a copy of the patient's insurance card with this form.

Date: ________________________________

Patient Name: (First, Middle Initial, Last): ______________________________________

Patient DOB: ____

Patient Daytime Phone: ____

Patient Evening Phone: ____

Patient Primary Insurance Carrier: ____

Services needed: (please circle):

* Integrative Psychiatry *Spravato (s-Ketamine) *TMS *Genetic Testing

* Medication Management *QEEG Brain Mapping *Precision Wellness *Psychotherapy

Referring Provider Name: ____

Provider Clinic Facility Name: ____

Provider Telephone: _______________________ Fax: ______________________________

Provider Address: ____

10333 19th Ave SE suite # 109 Everett, WA 98208 PH: 425-742-4600 Fax: 425-225-6859
1103 Cleveland Ave Mount Vernon, WA 98273 PH: 360-336-6868 Fax: 360-336-686

www.ShifaHealth.org