Shifa Health
Providing Quality Psychiatric Solutions

Referring Provider Information

Provider Name: _____

Clinic/Hospital/Practice Name: _____

Phone Number: _____

Fax Number: _____

Email Address: _____

Patient Information

Full Name: _____

Date of Birth: ____ / ____ / _____

Phone Number: _____

Email Address: _____

Insurance Provider: _____

Member/Policy Number: _____

Services Requested *(Check all that apply)*

☐ TMS
☐ Spravato
☐ QEEG-Brain Mapping
☐ 3x4 lifestyle Genetic Testing
☐ Burnout/Adrenal Fatigue Testing
☐ Medication Management
☐ Psychotherapy
☐ Psychiatric assessment

Reason for Referral

(Brief summary of diagnosis, symptoms, or concerns)

_____

_____

_____

Clinical Notes / Supporting Documents

Please upload or fax any relevant documentation (e.g., progress notes, diagnostics, prior treatment plans).

☐ Documents Attached
☐ Will Fax to: (Shifa Fax Number)

1103 Cleveland Ave, Mt Vernon, WA 98273
Ph: 360-336-6868 / Fax: 360-336-6866

10333, 19th Ave SE suite # 109 Everett, WA 9820
Ph: 425-742-4600 / Fax: 425-225-6859

www.Shifahealth.org

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Preferred Location (if applicable)

☐ Silver Lake
☐ Mount Vernon
☐ Telehealth

Authorization

By submitting this referral, I confirm that the patient has been informed of this referral and has consented to the release of necessary information to Shifa Health.

Referring Provider Signature: _____
Date: ____ / ____ / _____

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