HIVE

# REFERRAL FORM

**HIVE accepts patients age 18 and older with major depression, persistent depressive disorder, treatment-resistant depression along with bipolar disorder, chronic anxiety, PTSD, OCD, panic disorder, eating disorders and substance abuse.**

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## PATIENT INFORMATION

NAME OF PATIENT _____

DATE OF BIRTH _____

EMAIL _____

## DIAGNOSIS (Circle All That Apply)

- ☐ MAJOR DEPRESSIVE DISORDER
- ☐ TRD
- ☐ BIPOLAR DISORDER
- ☐ ANXIETY
- ☐ PTSD
- ☐ OCD
- ☐ SUBSTANCE ABUSE
- ☐ EATING DISORDERS

OTHER _____

COMMENTS OR SPECIAL INSTRUCTIONS _____

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## REFERRING PROVIDER INFORMATION

Please include pertinent patient medical records. We look forward to collaborating with you on your patient's treatment plan.

REFERRING PROVIDER NAME/DEGREE _____

COUNTRY _____

CITY _____

EMAIL

SPECIALTY

This patient and I would like to initiate treatments at HIVE. I have examined this patient and certify that to the best of my knowledge, there is not a medical contraindication for undergoing treatments at HIVE.

PROVIDER SIGNATURE DATE