HIVE

REFERRAL FORM

HIVE BIO Malta accepts patients age 18 and older with major depression, persistent depressive disorder, Treatment resistant depression along with chronic pain, anxiety, PTSD, panic disorder, substance and behavioural abuse.

PATIENT INFORMATION

NAME OF PATIENT*: _____

DATE OF BIRTH*: _____

GENDER: _____

EMAIL*: _____

Tel: _____

DIAGNOSIS (Circle All That Apply)

- ☐ MAJOR DEPRESSIVE DISORDER
- ☐ TRD
- ☐ ANXIETY
- ☐ PTSD
- ☐ CHRONIC PAIN
- ☐ SUBSTANCE ABUSE
- ☐ BEHAVIOURAL ABUSE

OTHER:_____

COMMENTS OR SPECIAL INSTRUCTIONS:

_____

_____

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 *: _____

REFERRING PROVIDER DEGREE *: _____

COUNTRY *: _____

HIVE

CITY *: _____

EMAIL *: _____

SPECIALTY *: _____

This patient and I would like to initiate treatments at HIVE BIO Malta. 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 BIO Malta.

PROVIDER SIGNATURE _____

DATE _____

* required to fill