

DATE OF REFERRAL *

REFERRAL RECEIVED BY (RAVIA USE ONLY)

RAVIA REFERENCE #

NOT FOR EMERGENCIES. Ravia Health does not provide crisis services. If the patient is at imminent risk, direct them to call or text 988 (Suicide & Crisis Lifeline), call 911, or go to the nearest emergency department.

1 Referring Provider

FULL NAME & CREDENTIALS *

NPI

PRACTICE / ORGANIZATION *

PHONE *

FAX

EMAIL *

OFFICE CONTACT (IF DIFFERENT)

2 Patient Information

FIRST NAME *

LAST NAME *

DATE OF BIRTH *

SEX ASSIGNED AT BIRTH (SELECT ONE)

☐ Female

☐ Male

☐ Intersex

☐ Prefer not to say

MOBILE PHONE *

EMAIL

STREET ADDRESS

CITY

STATE OF RESIDENCE *

ZIP

PREFERRED LANGUAGE

INTERPRETER NEEDED? (Y/N)

EMERGENCY CONTACT & PHONE

BEST TIME TO REACH PATIENT

☐ Morning

☐ Afternoon

☐ Evening

3 Coverage**PAYMENT TYPE (SELECT ONE) ***☐ UnitedHealthcare☐ FSA / HSA☐ Self-pay☐ Not sure**UNITEDHEALTHCARE PLAN NAME****MEMBER ID****GROUP #****POLICY HOLDER (IF NOT PATIENT)****POLICY HOLDER DOB****4 Reason for Referral***Check all that apply***PRESENTING CONCERNS ***☐ Depression☐ Anxiety☐ PTSD / trauma☐ ADHD☐ OCD☐ Insomnia☐ Obesity / metabolic health☐ Other**SERVICES REQUESTED**☐ Psychiatric evaluation☐ Medication management☐ Therapy☐ Weight / metabolic management☐ Consult only, return to referrer**WORKING DIAGNOSES / ICD-10 CODES****URGENCY (SELECT ONE) ***☐ Routine☐ Priority (within 1 week)**CLINICAL SUMMARY & REASON FOR REFERRAL (SYMPTOMS, DURATION, FUNCTIONAL IMPACT, WHAT HAS BEEN TRIED) *****CURRENT MEDICATIONS & RELEVANT HISTORY (PSYCHIATRIC & MEDICAL, PRIOR TRIALS, SUBSTANCE USE)****ALLERGIES**

5 Metabolic Data & Screening Scores*If available*

HEIGHT

WEIGHT

BMI

BLOOD PRESSURE

A1C

OTHER RECENT LABS (LIPIDS, TSH, ETC.)

PHQ-9 SCORE

GAD-7 SCORE

PCL-5 SCORE

OTHER SCREENING (NAME & SCORE)

6 Safety Screening

SELECT ONE *

☐ No current safety concerns☐ Passive SI or history, currently stable☐ Active or acute risk*If active or acute risk: refer the patient to 988, 911, or the nearest ED now. Submit this referral for follow-up once stabilized.*

SAFETY NOTES (HISTORY OF ATTEMPTS, HOSPITALIZATIONS, ACCESS TO MEANS, CURRENT SUPPORTS)

7 Records Attached☐ Recent visit notes☐ Labs☐ Medication list☐ Screening tools☐ Insurance card☐ Other**8 Confirmation & Signature**☐ The patient is aware of this referral and agrees to be contacted by Ravia Health to schedule care. (required)☐ Send me scheduling updates and a consult note once the patient is seen (with patient authorization).

REFERRING PROVIDER SIGNATURE *

DATE *

Submit: email the completed form to patientsupport@raviahealth.com or fax to 1-844-927-4910

Questions? Call (954) 329-0299. Our intake team contacts referred patients within 2 business days.