THRIVE
Flourish without restrictions

Referral to Thrive Center for Health

Referring Office/Provider:

Provider Name: _____ **Clinic:**_____
Phone Number:_____ **Fax:**_____
Email Address:_____
Address:_____

Thrive Center for Health Provider:
Clinic: Thrive Center for Health
Phone Number:(616)-805-3350 **Fax:**(616)-825-6337
Email Address:info@thriveketamine.com
Address:847 Parchment Drive SE, Suite 105, Grand Rapids, MI 49546

Patient Information:
Patient Name:_____ **DOB:**_____
Phone:_____ **Email:**_____
Address:_____
Reason for Referral: **Psych Med Management / IV or IM Ketamine / Pain**
_____
_____
_____

Please provide the following documentation in order for our office to proceed with providing care to your patient:

- Completed referral form
- Copy of ID and Insurance Card
- Any pertinent records pertaining to the patients mental health history