Kristina Vande Vrede, PsyD
WOMEN'S MENTAL HEALTH & PERINATAL SPECIALIST

PRESCRIBER CONTACT

To:_____ Date:_____
(Provider)

Re:_____ D.O.B.:_____
(Client's Name)

The above named client is currently in treatment with Dr. Kristina Vande Vrede. I understand that you are treating him/her and in an effort to collaborate treatment please provide the following information. Please return the form to my attention at the address listed below. A release of information authorization is attached. Thank you in advance for your cooperation.

Sincerely,

Kristina Vande Vrede, PsyD
551-427-1618

1) Diagnosis:

_____
_____

2) Current medications and dosages:

_____
_____

3) Type and frequency of treatment: _____Date of last visit:
_____

4) Critical history (e.g. suicidal ideation/thoughts, hospitalizations, past medication and reactions, etc.)

_____
_____

5) Do you have any treatment recommendations?

_____
_____

6.) Other comments and updates:

_____

Physician Signature:_____ Date:_____

Physician Phone #:_____