

# ISHA

## Patient Referral Letter

All fields are required for a qualified telemedicine referral

### Section 1: Referring Provider

First Name	Last Name	Credential
NPI	Speciality	Phone Number
Email	Fax Number	
Address(Street, Town, State, Zip)		

### Section 2: Patient Information

First Name	Last Name	DOB
Phone Number	Email	Gender
Reason for Referral		
Results of your in-person evaluation		
- Evaluation		
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- Diagnosis		
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- Treatment		

### Section 3: Provider Referred to

First Name <b>Mai</b>	Last Name <b>Shimada</b>	Credential <b>MD</b>
NPI <b>1316289523</b>	Speciality <b>Ketamine Treatment</b>	Phone Number <b>(415) 501-0812</b>
Email <b>info@isha.health</b>	Fax Number <b>(619) 415-8166</b>	
Address(Street, Town, State, Zip) <b>2021 Fillmore St Ste 1092 San Francisco, CA 94115</b>		