Transcranial Magnetic Stimulation (TMS) Referral Form

1. Patient Information
Name: ______________________________ DOB: _____________
Address: ____
Phone: ___________________ Email: ___________________________
Insurance: ___________________ ID#: _________________________

2. Referring Provider Information
Provider Name: __________________________________
Practice Name: __________________________________
Phone: ___________________ Fax: __________________
Email: ___________________ NPI#: _________________

3. Diagnosis Information (Required)
Primary Diagnosis: ______________________________
ICD-10 Code: _____________
Episode: ■ Single ■ Recurrent
Severity: ■ Moderate ■ Severe
Baseline Score (PHQ-9/MADRS/HAM-D): ______ Date: ______

4. Medication Trials (Required)
Medication | Dose | Dates | Response | Side Effects
____
____
____

5. Psychotherapy History
Type: ■ CBT ■ DBT ■ Psychodynamic ■ Other
Duration: ___________________ Response: ___________________

6. Previous Treatment History
ECT: ■ Yes ■ No
Ketamine/Spravato: ■ Yes ■ No
Prior TMS: ■ Yes ■ No
Hospitalizations: ________________________________

7. Medical Screening
Seizure History: ■ Yes ■ No
Metal in Head: ■ Yes ■ No
Implanted Device: ■ Yes ■ No
TBI: ■ Yes ■ No
Pregnancy: ■ Yes ■ No

8. Current Medications
Medication | Dose | Indication

____

____

9. Required Documents

- ■ Psychiatric Evaluation
- ■ Medication Trial History
- ■ Depression Rating Scale
- ■ Insurance Card
- ■ Progress Notes

10. Referring Provider Signature
Signature: ____________________________ Date: _____________