Deep Transcranial Magnetic Stimulation (dTMS) Clinician Referral Form

ARE THERE ANY CONTRAINDICATIONS TO RECEIVING TMS?:

Diagnosis of bipolar disorder?: ☐ YES ☐ NO
History of seizures?: ☐ YES ☐ NO
Active neurological disorder?: ☐ YES ☐ NO
Active psychotic symptoms?: ☐ YES ☐ NO
Electronic implants?: ☐ YES ☐ NO
Non-removable metal objects in head?: ☐ YES ☐ NO

NOTE: If YES to any of the above contradictions, the patient may not be considered a good candidate for TMS.

Patient Name: ______________________________ DOB: ______________
Phone: ______________________________
Email Address: ______________________________
Address: ______________________________
Insurance Carrier - be specific (NOTE: Medicaid does NOT cover TMS Services):
____
Insurance Member ID: ______________________________
Is the patient the subscriber?: ☐ YES ☐ NO
If NO, please list the subscriber's name as it appears on the insurance card:
____
Subscriber's DOB: ______________________________
Subscriber's Address: ______________________________
Major Depression Diagnosis (Fill in one): ☐ F32.2 ☐ F33.2
Other (Stormont - Vail BCBS or military payers only): ☐ F33.9 ☐ F33.1
Estimated length of current episode of depression: ______________________________
Has the patient received TMS treatment in the past?: ☐ YES ☐ NO
Has the patient received ECT treatment in the past?: ☐ YES ☐ NO
Current levels of impairment (work, school, social, sleep, mood, etc):
____
____
____

Referring Provider Information

Provider's Name: ______________________________
Phone: ______________________________
Fax: ______________________________
Address: ______________________________
Signature ______________________________ Date: ______________

Please fax the completed form to (888)965-5147

Antidepressant Trials:

	DOSAGE	START DATE	END DATE	REASON FOR DISCONTINUATION (PLEASE LIST ANY SIDE EFFECTS)
SERTRALINE (ZOLOFT)				
CITALOPRAM (CELEXA)				
FLUOXETINE (PROZAC)				
PAROXETINE (PAXIL)				
BUPROPION (WELLBUTRIN)				
VENLAFAXINE (EFFEXOR)				
OTHER: ____________				
OTHER: ____________				

Augmentation Trials:

	DOSAGE	START DATE	END DATE	OUTCOME
ABILIFY				
SEROQUEL				
OTHER				

Psychotherapy Trials:

PROVIDER	TYPE (EX. CBT)	DURATION (M/Y)	FREQUENCY

Previous psychiatric/mental health hospitalization?: ☐ YES ☐ NO
If yes, please fill out the following:

FACILITY	REASON FOR ADMISSION	DURATION (M/Y)	OUTCOME