PrimeTMS

Deep Transcranial Magnetic Stimulation (dTMS) Clinician Referral Form

Are there any contraindications to receiving dTMS?

Diagnosis of Bipolar Disorder?	◯ YES	◯ NO	Active psychotic symptoms?	◯ YES	◯ NO
History of seizures?	◯ YES	◯ NO	Electronic implants?	◯ YES	◯ NO
Active neurological disorder?	◯ YES	◯ NO	Non-removable metal objects in head?	◯ YES	◯ NO

NOTE: If YES to any of the above contraindications, the patient may not be considered a good candidate for dTMS

Patient Name: _____ DOB: ____/____/____ Phone: _____

Email: _____ Address: _____

INSURANCE CARRIER

◯ Aetna ◯ Coventry ◯ Medicare Advantage (UHC/AARP)
◯ BCBS of Kansas ◯ Federal BCBS (FEP) ◯ Tricare West ◯ UHC
◯ CIGNA ◯ HUMANA ◯ UMR ◯ UHC Student Resources
◯ Other:

Insurance Member ID: _____

Is the patient the subscriber?: YES/NO If NO, please list the subscriber's name: _____

Subscriber DOB: ____/____/____ Subscriber Address: _____

Major Depression Diagnosis: ◯ F32.2 ◯ F33.2 Other (Stormont-Vail BCBS or Military payers only) ◯ F33.9 ◯ F33.1

Estimated length of currnt episode of depression: _____

Has patient received TMS treatment in the past?: YES / NO Has patient received ECT treatment in the past?: YES / NO

Current levels of impairment (work, school, social, sleep, mood, etc.):

_____

Referring Provider Information

Provider Name: _____ Phone: _____ Fax: _____

Address: _____

Signature: _____ Date: ____/____/____

Antidepressant Trials:

Sertraline (Zoloft)	Dose:	Start:	End:
Citalopram (Celexa)	Dose:	Start:	End:
Fluoxetine (Prozac)	Dose:	Start:	End:
Paroxatine (Paxil)	Dose:	Start:	End:
Bupropion (Wellbutrin)	Dose:	Start:	End:
Venlafaxine (Effexor)	Dose:	Start:	End:
Other	Dose:	Start:	End:
Other	Dose:	Start:	End:

Augmentation Trials:

Abilify	Dose:	Start:	End:
Seroquel	Dose:	Start:	End:
Other	Dose:	Start:	End:

Psychotherapy Trials:

Provider: _____ Type (Ex: CBT): _____ Duration (M/Y): _____ Frequency: _____

Provider: _____ Type (Ex: CBT): _____ Duration (M/Y): _____ Frequency: _____

Previous psychiatric/mental health hospitilaztion? YES / NO

If yes, please fill out the following:

Facility:	Reason for admission:	Duration (M/Y):	Outcome:
_____	_____	_____	_____

Please fax completed form to (888) 965-5147