TMS Referral Form

Date: _______________

Patient Information:

Name: ____________________________________ DOB: __________________

Phone Number: (______)___________________

Referring Provider Information:

Name: ____________________________________ Phone Number: (______)___________________

Who is providing this patient's psychotherapy?

If patient doesn't currently see a therapist, check box: ☐

Name: ____________________________________ Phone Number: (______)___________________

Reason for Referral/Why is TMS medically necessary?

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Primary concerns/problems/history:

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____

Previous treatments/tests/procedures related to depression:

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____

____

Does the patient have at least 4 failed medications? Y / N

_____________________________ _____________________________ _______________

Signature of Referring Provider Print Name Date