



Physician Referral Form

Toll-Free Fax: (844) 204-2233
 info@tmssolutions.com
 Toll-Free Questions: (844) 537-6747

Patient Information

Name: _____ Birthdate: _____ Sex: _____
 Address: _____ City: _____ State: _____ ZIP: _____
 Preferred Phone: _____ Secondary Phone: _____
 Email: _____

Prescriber Information

Name: _____ Referral Date: _____
 Address: _____ City: _____ State: _____ ZIP: _____
 Phone: _____ Fax: _____ Office Contact: _____

Please Fax a Copy

- Clinical notes
- Prescription list
- Front and back of patient's insurance card(s)

TMS Screening Information

Names of antidepressants Patient has been prescribed in the past. _____

| <u>Yes</u> | <u>No</u> | Does the Patient have... |
|-----------------------|-----------------------|---|
| <input type="radio"/> | <input type="radio"/> | A seizure disorder? |
| <input type="radio"/> | <input type="radio"/> | A family history of seizure disorders? |
| <input type="radio"/> | <input type="radio"/> | Any history of brain illness or brain tumor? |
| <input type="radio"/> | <input type="radio"/> | An implanted metal device or object above the waist? (Exception: titanium, dental work, etc.) |

Diagnosis/Clinical Information (ICD-10 Codes)

| | | | | | | |
|---------------------------------|---|--------------------------------|--------------------------------|--------------------------------|---------------------------------|---------------------------------|
| <input type="checkbox"/> F32.9 | <input type="checkbox"/> F32.0 | <input type="checkbox"/> F32.1 | <input type="checkbox"/> F32.2 | <input type="checkbox"/> F32.3 | <input type="checkbox"/> F32.4 | <input type="checkbox"/> F32.5 |
| <input type="checkbox"/> F33.9 | <input type="checkbox"/> F33.0 | <input type="checkbox"/> F33.1 | <input type="checkbox"/> F33.2 | <input type="checkbox"/> F33.3 | <input type="checkbox"/> F33.41 | <input type="checkbox"/> F33.42 |
| <input type="checkbox"/> F32.89 | If selecting more than one diagnosis, please list primary diagnosis here: _____ | | | | | |

Relevant Medical, Psychiatric, Substance Abuse History, Trials of evidence-based psychotherapy known to be effective in the treatment of MDD – treatment type, start date, frequency, outcome, rating scale used, or Additional Comments:

Major Depressive Disorder (MDD)

Referring Physician Signature – Please Sign and Date Below

Signed: _____ Date: _____

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you received this document in error and then destroy it immediately. Pursuant to VA/OH/MO/VT law.

TMS Use Only: _____