TMS solutions | Advanced Depression Treatment

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. _____

Yes	No	Does the Patient have…
◯	◯	A seizure disorder?
◯	◯	A family history of seizure disorders?
◯	◯	Any history of brain illness or brain tumor?
◯	◯	An implanted metal device or object above the waist? (Exception: titanium, dental work, etc.)

Diagnosis/Clinical Information (ICD-10 Codes)

☐ F32.9 ☐ F32.0 ☐ F32.1 ☐ F32.2 ☐ F32.3 ☐ F32.4 ☐ F32.5

☐ F33.9 ☐ F33.0 ☐ F33.1 ☐ F33.2 ☐ F33.3 ☐ F33.41 ☐ F33.42

☐ 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: _____

TMS Use Only: _____