Transcranial Magnetic Stimulation (TMS) Clinician Referral Form

Patient Name: ____ **Date:** ____________

DOB: ______________________ **Phone:** ____

Address: ____

Insurance: ____

Diagnosis, estimated length of duration current episode of depression, and reason for referral:

____

____

____

____

Current medical conditions:

____

____

All current medications (for psychiatric or other medical conditions) and doses:

____

____

____

____

Medication trials during current episode of depression: Please include dose, duration, dates and response for each medication.

____

____

____

Psychotherapy trials:

____

____

Provider Name: ____

Address: ____

Phone: ________________ **Fax:** _________________ **Email:** ______________________

A completed referral form is required before a patient may complete his/her first TMS visit. If you have any questions, please call (785) 371-4921.

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

Prime TMS