UMassMemorial Medical Group

# Department of Psychiatry

## Transcranial Magnetic Stimulation (TMS) Referral Form

Phone: 508-334-1055 Fax: 774-441-6072

**Instructions: Indicate below all information about your patient. Please complete and fax clinical notes, to include psychiatric evaluation/Psych HPI, medical assessment, progress notes and all clinical scales (including PHQ9, etc).**

**REFERRING PHYSICIAN:**

Name: _____ Agency: _____

Phone: _____ Fax: _____

**PATIENT INFORMATION:**

Name: _____ Date of Birth: _____

Address: _____

Cell Phone: _____ Home phone: _____

Insurance and Identification #: _____

**PSYCHIATRIC DIAGNOSIS: Please include ALL psychiatric diagnosis(s) based on your evaluation and information from the referring provider.** Include which validation rating scales were used to support diagnosis of major depression (at least one is required and must be faxed). _____

_____

**MEDICAL CONDITION(S)**: _____

**MEDICATION TREATMENT HISTORY (current and past): Please include dosage, efficacy, side effects, reason for discontinuation. Please also include augmenting agents.**

| Medication | Dose | Start Date | End Date | Reason for Discontinuing |
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**TREATMENT HISTORY:**

Please list type of Therapy: Provider Giving Treatment: Frequency:

_____

History of seizures? Yes or No Current status:

History of substance use? Yes or No Current status:

Any ferromagnetic metals in and or around the head?

Previous TMS treatment? Yes or No When and where was the last treatment? _____

Previous ECT treatment? Yes or No When and where was the last treatment? _____