Transcranial Magnetic Stimulation (TMS) Referral Form

(to be filled out by referring provider)

TMS is an FDA-indicated treatment for major depression symptoms in individuals who have failed to respond adequately to medication therapies and psychotherapies or who have had difficulty tolerating medications due to negative side effects.

Patient Name: _____Telephone # _____

Address _____

Date of Birth: _____ Insurance Provider: _____

Insurance Phone #: _____ Policy Number _____

Referring Provider: _____

Address: _____

Office Phone # _____Office Fax # _____

Have You discussed TMS as a treatment option with the patient? YES____ NO_____

Does the patient have one of the following ICD-10 Diagnosis codes?

F32.2 ____ F33.2 ____ Other diagnosis code: _____

Has the Patient tried at least 4 antidepressant medications? YES____ NO_____

Please list prior or current antidepressant medications, including max doses, approximate dates of therapy, and any side effects that the patient experienced.

Has the Patient tried at least one course of psychotherapy? YES____ NO_____

If yes, please provide Name of therapist and approximate dates/number of sessions completed, if known

Any Prior ECT or TMS treatments? YES____ NO_____

Any non-removable metal objects in or around the patient's head? YES____ NO_____

Any history of seizures? YES____ NO_____

PLEASE FAX or MAIL Completed Form, along with relevant clinical information to:

Clinical TMS Physicians
UNC Psychiatry Outpatient Services
77 Vilcom Center Drive Suite #300, Chapel Hill, NC, 27514
Fax: 984-974-9646 • Phone: 984-974-5217