**SHEPPARD PRATT OUTPATIENT TMS REFERRAL**

*TO BE COMPLETED BY REFERRING PHYSICIAN*

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_

Insurance Company (if known) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy # \_\_\_\_\_\_\_\_\_\_\_

ICD-10 Codes: Primary Dx: \_\_\_\_\_\_\_\_\_\_\_\_Secondary Dx(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for TMS Consult/Treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**To your knowledge, does the patient have anything of metallic nature implanted and non-removable in the head, neck, or chest? (Circle): YES NO**

Date the current episode Depression began: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Psychiatric Medications:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name | Dose | Start Date | End Date | Reason if D/C |
|  |  |  |  |  |
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Psychotherapy History (CBT, Psychoanalysis, DBT, Other):

|  |  |  |
| --- | --- | --- |
| Type/Frequency of Visits | Start Date | Current: Y/N? |
|  |  |  |
|  |  |  |

Psychiatric Treatment History (Circle all that apply): TMS, ECT, Ketamine, VNS. **Explain/Add**:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Psychiatric Symptoms **Last 3-6 mos.**: (Circle all that apply): Acutely suicidal, psychotic, mixed state, severe depressed mood, anxiety, alcohol or substance abuse. **Explain/Add**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Other History of Psychiatric Disorders: (Circle all that apply): Eating Disorder, Dementia, Traumatic Brain Injury. **Explain/Add:**

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Additional Psychiatric History of Significance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Medical History: (Circle all that apply): Seizure Disorder, Cardiovascular Disease, Cerebrovascular Disease, Migraines. **Explain/Add:**

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Medical Medications (List type and dose): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Referring Physician Signature/Date:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Physician Printed Name and Email Contact or Phone Number:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Fax completed form to: (410) 938-3474, Attn: TMS Services**

**If you have any questions, call (410) 938-4037**