Sheppard Pratt

SHEPPARD PRATT OUTPATIENT TMS REFERRAL

TO BE COMPLETED BY REFERRING PSYCHIATRIC PROVIDER

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? (check): ☐ YES ☐ NO

Date the current episode depression began: _____

Psychiatric Medications:

Name	Dose	Start Date	End Date	Reason if D/C

Psychotherapy History (CBT, Psychoanalysis, DBT, Other):

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

Psychiatric Treatment History (check all that apply): ☐ TMS ☐ ECT ☐ Ketamine ☐ VNS

Explain/Add:

Psychiatric Symptoms **Last 3-6 mos.**: (check all that apply):

☐ Acutely suicidal ☐ Psychotic ☐ Mixed state ☐ Severe depressed mood

☐ Anxiety ☐ Alcohol or substance abuse **Explain/Add**:

Other History of Psychiatric Disorders: (check all that apply): ☐ Eating Disorder

☐ Dementia ☐ Traumatic Brain Injury **Explain/Add:**

Additional Psychiatric History of Significance:

Medical History: (check all that apply): ☐ Seizure Disorder ☐ Cardiovascular Disease

☐ Cerebrovascular Disease ☐ Migraines **Explain/Add:**

Medical Medications (List type and dose):

Referring Physician Signature/Date:

_____

Referring Physician Printed Name and Email Contact or Phone Number:

_____

Fax completed form to: (410) 938-5075, Attn: TMS Services
If you have any questions, call (410) 938-4037