Transcranial Magnetic Stimulation (TMS) Clinician Referral Form

We are currently FDA approved to treat MDD, Anxious Depression, and OCD. At this time, we cannot treat patients with Bipolar disorder.

Patient Name: ____

DOB:_____________**Phone:**________________**Email:**___________________

Address:____

Primary Insurance:____

Secondary Insurance:____

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

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How many past episodes of MDD? ____

Current medical conditions:____

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

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____

Medication trials during current episode of depression:

Please list as much information you have regarding dose, date and duration of trial, response for each medication, and if stopped due to side effects

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Medication trials in past episodes of depression or OCD:

Please list as much information you have regarding dose, date and duration of trial, response for each medication, if stopped due to side effects:_______________________________________

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Psychotherapy trials:____

Psychiatric Prescriber:____

Address of Prescriber:____

Phone:__________________**Fax:**____________________**Email:**___________

If you have any questions regarding TMS, please call our office at (774) 929-6797 **or email** info@neurohealthconsulting.net. **Thank you for your referral.**