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Transcranial Magnetic Stimulation (TMS) Clinician Referral Form and Requirements

Please complete the enclosed form and fax with records to (214) 613-1667. The following are helpful in evaluating and obtaining a prior authorization:

☐ Patient Referral Form
☐ Copy of Insurance Card Front and Back
☐ Current and Previous Medication Records
☐ Most Recent Depression Measure (MADRS or PHQ-9)

After we receive your referral form, we will do the following:

- We will contact your patient to schedule a screening appointment and discuss treatment, answer preliminary questions, and collect any other relevant information needed.
- We will gather and submit the required documentation for prior authorization approval with insurance.
- We will update you when your patient is scheduled with us and again following initial treatment to share information regarding treatment response.

Transcranial Magnetic Stimulation (TMS) Clinician Referral Form

Referral Submission Date: ____________________

Patient Demographic Information

Name: ____________________ DOB: ____________________

Address: ____________________ City, State, Zip: ____________________

Phone: ____________________ Email: ____________________

Insurance Information (We are in-network with BCBS TX PPO)

Insurance: ____________________ Cardholder Name: ____________________

Member ID: ____________________ Group Number: ____________________

Clinical Information

Primary Diagnosis for Referral:

☐ F33.2 Major depressive disorder, Recurrent episode, Severe
☐ F33.1 Major depressive disorder, Recurrent episode, Moderate
☐ F32.2 Major depressive disorder, Single episode, Severe
☐ F32.1 Major depressive disorder, Single episode, Moderate
☐ F42.2 Obsessive Compulsive Disorder
☐ Other: ____

Estimated Date of Onset: ____________________________

Antidepressant Medication History

Medication Name	Max Dose	Dates Started/Stopped	Result

Currently or Previously in Psychotherapy?

☐ Yes, Currently Provider Name: ____________________ Started: ____________________

☐ Yes, In Past Provider Name: ____________________ Dates: ____________________

☐ No.

Are any of the Following Conditions Present?

☐ None of the above are present.

☐ Seizure disorder or any history of seizure disorder (except those induced by ECT or isolated febrile seizures in infancy without subsequent treatment or recurrence)

☐ Presence of acute or chronic psychotic symptoms or disorders in the current depressive episode (such as, schizophrenia or schizoaffective disorder)

☐ Neurological conditions that include history of epilepsy, cerebrovascular disease, dementia, increased intracranial pressure, repetitive or severe head trauma, or primary or secondary tumors in the central nervous system

☐ Excessive use of alcohol or illicit substances within the last 30 days

☐ No response by patient to a prior course of rTMS treatments (defined as not achieving at least a 50% reduction in severity of scores for depression in a standardized rating scale, i.e. PHQ-9, by the end of acute phase treatment)

☐ The patient has received a separate acute phase rTMS treatment in the past 6 months

Other Current Medical Conditions/Psychiatric Diagnoses

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Current Medications

Medication Name	Dose	Directions

Referring Provider Information

Provider Name: ______________________ Phone: ______________________

Practice Name: ______________________ Fax: ______________________

Email: ______________________

Please notify me with updates regarding my patient through: ☐ Phone / ☐ Fax / ☐ Email

Referring Provider Signature: ______________________ Date: ______________