Transcranial Magnetic Stimulation (TMS) Clinician Referral Form

Patient Name: _____ **Date:** _____

DOB: _____ **Phone:** _____

Address: _____

Insurance: _____

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

_____

_____

Current medical conditions:

_____

_____

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

_____

_____

_____

_____

Medication trials during current episode of depression: Please include dose, duration, dates and response for each medication.

_____

_____

_____

Psychotherapy trials:

_____

_____

Physician Name: _____

Address: _____

Phone: _____ **Fax:** _____ **Email:** _____

A completed referral form is recommended to accelerate getting your patient to their first TMS visit. If you have any questions regarding TMS, please call 1-619-267-9257 or Toll Free at 1-855-ILUVTMS

Please fax the completed form to 619-267-9273
Additional Contacts
TMS Operations - Corey Scott PharmD - scottc@pacifichealthsystems.com
National City TMS Lead Tech - Jenna Gomez - gomezj@pacifichealthsystems.com
Oceanside TMS Lead Tech - Jessica Piazza - jpiazza@nccresearch.com