



DENVER WELLNESS ASSOCIATES
your path to well being

TMS Referral Form – Evaluation for Transcranial Magnetic Stimulation

Phone: (720) 724-368

Fax: (720) 598-0480

Email: info@denverwellness.com

Patient Information

Patient Name: _____

DOB: _____

Phone: _____

Insurance Information

Primary Insurance: _____

Secondary Insurance: _____

Insurance ID: _____

Note: Medicaid and some Medicare Advantage plans not accepted.

Diagnosis

- F32.x – Major Depressive Disorder, Single Episode
- F33.x – Major Depressive Disorder, Recurrent
- F34.1 – Persistent Depressive Disorder (Dysthymia)
- F42.x – Obsessive Compulsive Disorder
- Other: _____

Clinical Summary/Reason for Referral

(Include severity, duration, functional impairment, and rationale for TMS)

Current Medications

See table below

Medication	Dose	Duration

Medication Trials Failed

Patient has trialed ≥ 2 antidepressants from different classes at adequate dose/duration

Medication	Dose	Dates	Reason Stopped

Prior Treatments

- Psychotherapy (type/frequency): _____
- ECT
- Ketamine / Spravato
- Other: _____

Contraindications

- Metallic implant in or near head (excluding dental work)
- Cochlear implant
- Implanted neurostimulator (DBS, VNS, etc.)
- Other: _____

Seizure History

- No history of seizures
- History of seizure(s)
 - Type: _____
 - Date of last seizure: _____
 - Cause (if known): _____
- On anticonvulsant? Yes No

Relative Risk Factors

- History of seizures
- History of bipolar disorder or mania
- Traumatic brain injury
- Substance use history
- Medications that lower seizure threshold
- Pregnancy
- Other: _____

Recent Clinical Information (Attach if Available)

- Most recent psychiatric follow-up note
- Psychiatric evaluation / intake
- Medication list
- PHQ-9 or other rating scales
- Insurance authorization information (if started)

Additional Notes:

Provider Attestation

I am referring this patient for evaluation for TMS and confirm that the above information is accurate to the best of my knowledge.

Provider Signature: _____

Date: _____

Instructions

Please fax completed form and supporting documentation to: **(720) 598-0480**. Our team will review and contact the patient to schedule an evaluation.