DENVER WELLNESS ASSOCIATES
your path to well being

TMS Referral Form – Evaluation for Transcranial Magnetic Stimulation

Phone: (720) 724-3668
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:

Insert Text Here

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.