UMass Memorial Health
HARRINGTON HOSPITAL

Transcranial Magnetic Stimulation (TMS) Referral Form

Phone: 508-765-2225 Fax: 508-334-4046
Email: TMS@UMASSMemorial.org

Instructions: Indicate below all information about your patient. Please complete and fax clinical notes, to include psychiatric evaluation/psych HPI, medical assessment, progress notes and all clinical scales (including PHQ 9, etc.).

REFERRING PHYSICAN:

Name: _____ Agency: _____

Phone: _____ Fax: _____

PATIENT INFORMATION:

Name: _____ Date of Birth: _____

Address: _____

Cell Phone: _____ Home Phone: _____

Insurance and Policy #: _____

PSYCHIATRIC DIAGNOSIS: Please include ALL psychiatric diagnosis(s) based on your evaluation.

_____

_____

Medical Conditions _____

History of Seizures? Yes or No

TREATMENT HISTORY:

Please list type of Therapy: Provider Giving Therapy: Frequency:

_____

MEDICATION TREATMENT HISTORY: Current and past

Medication	Dose	Start date	End Date	Reason for Discontinuing