

NeuroStar TMS Referral Form

PLEASE REVIEW BEFORE SUBMITTING REFERRAL

The NeuroStar TMS Therapy System is contraindicated for use in patients who have conductive, ferromagnetic, or other magnetic-sensitive metals implanted in their head within 30cm of the treatment coil. **TMS therapy is not a viable treatment option for individuals with the following contraindications:**

- Cochlear implants
- DBS (any) Implanted electrodes/simulators
- Stents
- Ferromagnetic ocular implants
- Metallic devices implanted in the head
- EEG electrodes
- Device leads
- Pacemaker
- Implanted, previously removed or wearable Cardioverter Defibrillator
- Magnetically activated dental implants
- Facial tattoos with metallic ink
- Non-removable stainless steel (piercings)
- Vagus nerve stimulators
- Cerebral Spinal Fluid Shunt
- Aneurysm clips/coils
- Pellets, bullets, fragments within 30cm from coil

NeuroStar Advanced Therapy Referral Form
Completed by patient's medical provider and faxed to (563) 328-5690

Today's Date: _____

Patient Information

Last Name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Social Security #:
Birth date:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Race:	Phone #:	
Address:			Language:	Alternate Ph #:	
City:		State:		Zip Code:	
Primary Family Doctor:			Primary Doctor Fax #:		
Primary Doctor Ph #:					
Please list all patient diagnoses:					

Insurance Information

Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		Primary Insurance:			
Subscriber's Name:	Subscriber's SS #:	Birth date:	Group #:	Policy #:	
Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	
(IF APPLICABLE) Secondary Insurance:					
Subscriber's Name:	Subscriber's SS #:	Birth date:	Group #:	Policy #:	
Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	

Referral Source

Name of facility:	Referred by:
Complete Address:	
Office Phone #:	Office Fax #:
Contact Person:	

NeuroStar Advanced Therapy Patient Information Form

1. Is the patient at least 18 years of age?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
2. Is the patient pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
3. Does the patient have a confirmed DSM-V diagnosis of a Major Depressive Disorder, Severe? Majority of insurances are only covering Severe MDD W/Out Psychotic Features.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
4. Was evidence-based psychotherapy for depression attempted of an adequate frequency without significant improvement in depressive symptoms? If "yes", please notate the providers name, as well as duration of therapy and the outcome below.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
5. Is there a clinical contraindication for ECT?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
6. Does the patient have a history of response to ECT in a previous or current episode, or an inability to tolerate ECT?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
7. Did the patient refuse ECT?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
8. Does the patient have any psychotic symptoms in the current depressive episode?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
9. Does the patient have any neurologic conditions that include epilepsy, cerebrovascular disease, dementia, increase intracranial pressure, having a history of repetitive or severe head trauma, or with primary or secondary tumors in the central nervous system? If "yes", please state which condition(s):	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
10. Is the patient medically stable and the patient's status and/or comorbid medical conditions not contraindications for TMS?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
11. Has the individual had previous TMS? If so, when was the last course of TMS completed? If "yes", is this referral for: <input type="checkbox"/> Maintenance Therapy <input type="checkbox"/> Continuous Therapy <input type="checkbox"/> Rescue Therapy <input type="checkbox"/> Extended Active Therapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
12. Is there documentation of a clinical evaluation performed by a psychiatrist who is appropriately trained to provide TMS to include all of the following: <ul style="list-style-type: none"> • Psychiatric history • Past response to antidepressant medication • Past response to TMS • Past response to ECT • Mental status • Current functioning 	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

NeuroStar Advanced Therapy Patient Information Form

Please indicate if the patient has any of the following:					
Aneurysm clips or coils	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Wearable cardioverter defibrillator	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cardiac pacemaker or wires	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Implanted insulin pump	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Internal cardioverter defibrillator (ICD)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Programmable shunt or valve	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Carotid or cerebral stents	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hearing aid	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Deep brain stimulator	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cervical fixation devices	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Metallic devices implanted in your head	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Surgical clips, staples, or sutures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dental implants	<input type="checkbox"/> Yes	<input type="checkbox"/> No	VeriChip microtransponder	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cochlear implant/ear implant	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Wearable monitor (e.g., heart monitor)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
CSF (cerebrospinal fluid) shunt	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bone growth stimulator	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Eye implants	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Wearable infusion pump	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cardiac stents, filters, or metallic valves	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Radioactive seeds	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tattoo	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Portable glucose monitor	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Vagus nerve stimulator (VNS)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tracheostomy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood vessel coil	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Medication patch/nicotine patch	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Shrapnel, bullets, pellets, BBs, or other metal fragments	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other implanted metal or device	<input type="checkbox"/> Yes	<input type="checkbox"/> No
			If yes, please specify:		

Questions modified from Johns Hopkins Medicine Department of Psychiatry and Behavioral Sciences TMS Patient Screening Form

Has the patient ever been a machinist, welder, or metal worker? Yes No

Has the patient had a facial injury from metal and/or metal removed from their eyes? Yes No

Has the patient had complications from an MRI? Yes No

If you answered "Yes" to any of the above questions, please provide additional information on the following page

Provider Name (print):

Provider Signature:

Date:

Additional Information/Comments

Provider Name (print):

Provider Signature:

Date:
