VERA FRENCH
Mental Health for Healthy Living

NeuroStar TMS Referral Form

PLEASE REVIEW BEFORE SUBMITTING REFERRAL

The NeuroStar TMS Therapy System is contraindicated for use in 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

NeuroStar Advanced Therapy Referral Form

To be completed by patient's medical provider and faxed to 563-888-8064.
For referral questions, please call 563-888-6258.

Today's Date:_____

Patient Information

Last Name:		First:	Middle:		❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.	Social Security #:
Birth date:	Age:	Sex: ❑ M ❑ F	Height:	Date of Vitals:	Phone #:	
			Weight:		Alternate Ph #:	
Address:						
City:			State:		Zip Code:	
Primary Family Doctor:						

Insurance Information

Is this patient covered by insurance? ❑ Yes ❑ No		Primary Insurance:		
Subscriber's Name:	Subscriber's SS #:	Birth date:	Group #:	Policy #:
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other
(IF APPLICABLE) Secondary Insurance:				
Subscriber's Name:	Subscriber's SS #:	Birth date:	Group #:	Policy #:
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Referral Source

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

Vera French Community Mental Health Center | 1441 W. Central Park Avenue Davenport, IA 52804 Phone: (563) 888-6258 | Fax: (563) 888-8064

1.	Does the patient have a confirmed DSM-V diagnosis of Major Depressive Disorder? Majority of insurances are only covering Severe MDD without Psychotic Features.	❑ Yes	❑ No	
2.	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:**	❑ Yes	❑ No	
3.	Is there a clinical contraindication for ECT?	❑ Yes	❑ No	❑ NA
4.	Does the patient have a history of response to ECT in a previous or current episode, or an inability to tolerate ECT?	❑ Yes	❑ No	❑ NA
5.	Did the patient refuse ECT?	❑ Yes	❑ No	❑ NA
6.	Does the patient have any psychotic symptoms in the current depressive episode?	❑ Yes	❑ No	❑ NA
7.	Has the patient had any prior psychiatric hospitalizations? If "yes", please explain:	❑ Yes	❑ No	
8.	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):	❑ Yes	❑ No	
9.	Does the patient have any prior or recent substance and/or alcohol use? If "yes", please explain:	❑ Yes	❑ No	
10.	Is the patient medically stable and the patient's status and/or comorbid medical conditions not contraindications for TMS (see page 1)?	❑ Yes	❑ No	❑ NA
11.	Has the individual had previous TMS? If so, when was the last course of TMS completed? If "yes", is this referral for: ❑ Maintenance Therapy ❑ Continuous Therapy ❑ Rescue Therapy ❑ Extended Active Therapy	❑ Yes	❑ No	
12.	Has the patient had little/no response or side effects to at least 3 antidepressant medications? **Please list 3 to 4 antidepressant medications, including max doses, approximate dates of therapy, and reason for discontinuation:**	❑ Yes	❑ No	

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Complete Medication List

(If not attached with office visit notes)

Name	Dose	Directions

Additional Information/Comments

Please send most recent office visit notes

Name of person completing form (print): _____

Signature: _____ Date: _____

Internal Use Only

Vera French Staff reviewed with referred individual on _____/_____/_____ Initials_____

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