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

Updated 8/2025 KB

NeuroStar Advanced Therapy Referral Form

To be completed by patient's medical provider and faxed to 563-888-8064
If you are not established with a medical/mental health provider, please call 563-888-6358
Please fill out this packet in its entirety.

Today's Date:_____

Patient Information

Last Name: First: Middle:				❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.	Social Security #:
Birth date:	Age:	Sex: ❑ M ❑ F	Height: Weight:	Race: Language:	Phone #: Alternate Ph #:
Address:					
City:			State:		Zip Code:
Primary Family Doctor:					
Primary Doctor Ph #:				Primary Doctor Fax #:	
Please list all patient diagnoses **(ICD10)**:					

Insurance Information (or attach copy of insurance card)

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:	

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? **Please list details on last page of referral packet.**	❑ 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 (within the past 4 weeks) 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 details on last page of referral packet.**	❑ Yes ❑ No

PLEASE COMPLETE TO THE BEST OF YOUR ABILITY

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

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 below

Treatment History

Patient Name:_____

Date form completed: _____/_____/_____

The information requested in this form is based upon the criteria required by most insurance providers.
Not providing this information may result in a denied referral or denial of coverage in the prior authorization process.

Medications:

Please provide at least four medications of two different classes

Medication Name	Highest Dose	Start Date (mm/yy)	End Date (mm/yy)	Reason Ended

Talk Therapy (CBT, DBT, etc.):

Please list any ongoing or recent therapy trials

Organization	Therapist Name	Start/End Dates (mm/yy)	Response

Diagnoses (DX):

Please list patient diagnoses related to mental health, including one of major depression

ICD-10 DX	Date of Dx (mm/yy)	Dx Provider	Comments