TRANSCRANIAL MAGNETIC STIMULATION (TMS) CONSULTATION
CLINICIAN REFERRAL FORM

Patient Name: **Date of Referral:**

Date of Birth: **BMC MRN (if applicable):**

Phone number: **Email address:**

Insurance Plan(s):

Diagnosis, length of duration of current episode, reason for referral:

Current Medical Conditions:

Prior and Current Antidepressant Trials (please note that most insurances require >4 trials across >2 classes): please include dose, duration, dates, and response to each medication

Psychiatrist's Information:

Name: **Address:**

Phone: **Fax:** **Email:**

A completed referral form is required before a patient may complete their first TMS visit. Please email the completed form to TMS@bmc.org or fax 781-398-7222.