HOPEWAY
PSYCHIATRY & ASSOCIATES

TMS Referral Form

Please provide information to consider your patient for TMS. Contraindications include: History of any metal objects in the brain (e.g. wires or stents), history of seizures, current significant substance use, or significant cognitive impairment.

Client Demographics		
Name:	Date of Birth (MM/DD/YYYY):	Sex:
Email:	Preferred Phone Number:	

Referring Provider Information	
Name:	Practice/Clinic:
Address, City, State, Zip:	
Phone Number:	Email:

Client History	
Major Depression, Treatment Refractory: Yes ◯ No ◯	PHQ9 Score (if known):
History of Psychotherapy: Yes ◯ No ◯	Last Date of Psychotherapy Appointment (if known):
Psychiatric Diagnoses (list):	Currently Active Medical Conditions/Comorbidities:

Antidepressants Used in Past Year					
Medication Name	**Duration Taken (# months or years total)**	**Max Dose Used**	**Still Taking?**	**Response**	**Discontinued for side effects/lack of efficacy?**
				◯ None ◯ Partial ◯ Transient	
				◯ None ◯ Partial ◯ Transient	
				◯ None ◯ Partial ◯ Transient	
				◯ None ◯ Partial ◯ Transient	

Previous Treatment History
Please provide a summary of previous Esketamine, TMS, or ECT treatment, if applicable. Include dates and number of treatments, response, and/or complications:

Psychiatric History
History of Psychiatric Admissions, Suicide Attempts, Psychotic Episodes, and Substance Use Disorder:

If you wish to fax this form, please send to the attention of HopeWay Psychiatry & Associates at 980-321-0076