MH 734

# MOBILE TRANSCRANIAL MAGNETIC STIMULATION (TMS) REFERRAL FORM

## Referral Information:

Client ID #: __________________________ Referral Date: ____________________

Client Name: ____________________________________________________________ DOB: _________/________/________

Address: ____________________________________________________ City: ______________________ Zip: ________________

Telephone: ______________________________________________ Preferred Language: __________________________________

**Current Mental Health Services (Please check one):** ☐PEI ☐RRR ☐FSP

**Client has one of the following diagnoses (it not, TMS referrals are not accepted at this time):**

☐ Major Depressive Disorder ☐ Bipolar Disorder, Current Episode Depressed ☐ Dysthymia ☐ Schizoaffective Disorder, Depressed Type

**Does the client have a Co-Occurring Substance Use Disorder?** ☐Yes ☐ No

## Reason for Referral:

## List all current and previous psychotropic medications prescribed to the client:

## History of psychotherapy – how has the client responded to psychotherapy?

## Additional Referral Information:

Does the client have……

1. Metal implants in the head or upper torso (e.g., cardiac pacemakers)? ☐Yes ☐ No
2. History of Seizure(s)? ☐Yes ☐ No
3. Previous history of TMS treatment? ☐Yes ☐ No
   If yes, how long ago was the treatment and how many sessions were given?
   ________________________________________________________________
4. Inability to tolerate or unresponsiveness to psychopharmacological agents? ☐Yes ☐ No

**This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure or use is prohibited without the prior written authorization of the individual/authorized representative to who it pertains unless otherwise permitted by law.**

**Referring Provider:** ____________________________________________________________

**Referring Staff:** ________________________________________________________________

**Telephone #:** ___________________________________________________________________

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**Name:** **DMH ID #:**

**Agency:** **Provider #:**

**Los Angeles County – Department of Mental Health**