MH 734
Revised 10/08/2025

Transcranial Magnetic Stimulation (TMS) Referral Form for Specialty Mental Health Services Clients

Referral Date

Date:

Client Information (Client must be age 18 and older)

Client Name: DOB:

IBHIS #:

Preferred Language:

Telephone:

Address: City: Zip:

Medi-Cal #:

Referring Provider Information:

Provider Name & Provider #:

Referring Psychiatrist Name:

Psychiatrist Email and/or Phone:

Secondary Contact Name:

Secondary Contact Email and/or Phone:

Reason for Referral:

- ☐ Not responding to medications
- ☐ Undesirable side effects with medications
- ☐ Other (Please describe):

Mental Health Diagnosis

All current and previous psychotropic medications prescribed to the client:

Current medications:

Previous medications:

Additional Referral Information

☐ Most Recent Initial Medication Evaluation & Medication Progress Note Attached