

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

Referral Date		
Date:		
Client Information (Client must be age 15 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:		
<input type="checkbox"/> Not responding to medications		
<input type="checkbox"/> Undesirable side effects with medications		
<input type="checkbox"/> Other (Please explain below)		

Mental Health Diagnosis		
Please list medication trials and dosages (include combinations tried and dates)		
Current medications:		
Previous medications:		
Additional Referral Information		

Most recent Initial Medication Evaluation & Medication Progress Note Attached