Transcranial Magnetic Stimulation (rTMS)Treatment for Drug Resistant Depression Referral Form – **Page 1** (REQUIRED)

Berenson-Allen Center for Noninvasive Brain Stimulation
Beth Israel Deaconess Medical Center
330 Brookline Avenue KS -158
Boston, MA 02215

Directions:
Please fill out Page 1 of form in its entirety (Any section with an * is **required,** info is **critical** for **prior authorization)**
See **Page 2** of form (optional) if any:

- Additional past medications were used
- Additional current medications are used

Date: ___________________

Referrer Information: *

Name:	Profession:
E-mail:	Day Phone:
Please check preferred method of communication: E-Mail ❑ or Office Phone ❑	

Patient Information: *

Name:	DOB:	MRN: (if BI patient):
Day Phone:	Email:	
Please check preferred method of communication: E-Mail ❑ or Phone ❑		

Patient Narrative * - Give a brief description of patient's history (Please include any prior hospitalizations, TMS, and/or ECT)

Diagnoses (please list all diagnoses)

Diagnosis*	Onset (mm/yyyy)	Comments
Primary:	/	
Secondary:	/	
Additional (if applicable):	/	

Past Medication Trials (please list all past medication trials for depression – ***4 different classes required***)

Medication*	Start (mm/yyyy)	Duration*	Dose*	Response / Side Effects / Reason for Discontinuation*
	/			
	/			
	/			
	/			

Current Medications (please list all current medications)

Medication*	Start (mm/yyyy)	Dose*	Current Response / Side Effects
	/		
	/		
	/		
	/		
	/		

Transcranial Magnetic Stimulation (rTMS)Treatment for Drug Resistant Depression Referral Form – **Page 2** (Optional)

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Beth Israel Deaconess Medical Center
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- Additional past medications were used
- Additional current medications are used

Date: ____________________

Diagnoses (please list all diagnoses)

Diagnosis	Onset (mm/yyyy)	Comments
Primary:	/	
Secondary:	/	
Additional (if applicable):	/	

Past Medication Trials (please list all past medication trials for depression – ***4 different classes required***)

Medication	Start (mm/yyyy)	Duration	Dose	Response / Side Effects / Reason for Discontinuation
	/			
	/			
	/			
	/			

Current Medications (please list all current medications)

Medication	Start (mm/yyyy)	Dose	Current Response / Side Effects
	/		
	/		
	/		
	/		
	/		

Other Comments: