

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

Referrer Information: *

Date: _____

Name:	Profession:
E-mail:	Day Phone:
Please check preferred method of communication: E-Mail <input type="checkbox"/> or Office Phone <input type="checkbox"/>	

Patient Information: *

Name:	DOB:	MRN: (if BI patient):
Day Phone:	Email:	
Please check preferred method of communication: E-Mail <input type="checkbox"/> or Phone <input type="checkbox"/>		

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
	/		
	/		
	/		
	/		
	/		

Please complete all sections to assist with timely review and return this form to:

Fax: 617-975-5322 | Phone: 617-667-0307

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

**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: _____

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:

Please complete all sections to assist with timely review and return this form to:

Fax: 617-975-5322 | Phone: 617-667-0307