# Transcranial Magnetic Stimulation (rTMS)Treatment Referral Form

**Berenson-Allen Center** for Noninvasive Brain Stimulation
Beth Israel Deaconess Medical Center
330 Brookline Avenue KS -158
Boston, MA 02215
617-667-0307 (phone) 617-975-5322 (fax)

Directions:
**Please fill out this form in its entirety (**Any section with an * is **required,** info is **critical** for **prior authorization)**
Once complete please return to the form via: Fax: 617-975-5322 or TMSReferrals@bidmc.harvard.edu.

**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 ☐ | | |
| **Condition for which rTMS is being requested:** Depression ☐ or Other Indication ☐ _____ | | |

**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* | Comments |
|---|---|
| **Primary:** | |
| **Secondary:** | |
| **Additional (if applicable):** | |

**Past Medication Trials** (please list all past medication trials for depression)

| Medication* | Dose* | Response / Side Effects / Reason for Discontinuation* |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Current Medications** (please list all current medications)

| Medication* | Dose* | Current Response / Side Effects |
|---|---|---|
| | | |
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