

TMS Center Referral Form → Fax completed form to 802.776.2796

Referral sent by: _____ Phone: _____

Referral to which Service: Transcranial Magnetic Stimulation
 Reason for Referral: Treatment-Resistant Major Depressive Disorder, severe, without psychosis

Patient Name: _____ Age: _____ DOB: _____
 Address: _____ Phone (home): _____
 _____ (work): _____

Insurer: _____ Phone: _____
 Policy Holder: _____ Policy Number: _____

Current Prescriber's Name: _____
 Address: _____ Phone: _____

Current Psychotherapist's Name: _____
 Address: _____ Phone: _____

Diagnosis (Severe MDD required): _____ PHQ-9Score (15-27 required): _____

Current Medications: _____

Previous Medication Trials (Requires Resistance or Intolerance to >2 Medications of Different Classes)¹:

Dates of Treatment	Medication Name	Dose	Duration (6 weeks) ²	Reason for Failure

¹Aetna requires 2 different classes + 1 augmented. Humana requires 4 medications of 2 different classes. MVP requires 4 medications if failure is due to intolerance.

²Aetna requires 8 weeks within last 5 years. Cigna requires 4 weeks. MVP requires 8 weeks.

Previous Psychotherapy Trials (1 Failed Trial Required)³

Dates of Treatment	Type of Psychotherapy	Duration/Number of Sessions	Reason for Failure

³Not required for Optum and Aetna. MVP requires a failed psychotherapy trial of 3-6 months duration.

Referral Ordered by: _____ Date: _____

Form # 5517 Created 01/26  * 1 6 0 0 *		Patient Label
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