POLARIS PSYCHIATRY

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# TMS Referral Form

*TMS is a non-invasive, FDA-approved treatment for depression in patients who have not responded to two or more medication trials. It can also be used for OCD and smoking cessation.*

**Please forward (1) this signed form, (2) your intake note, and (3) your last progress note to either Fax: 860-590-3921 or our secure Email: info@polarispsychiatry.com. We cannot obtain insurance approval without all three documents. We will manage all patient and insurance contact directly.**

Patient's Name: _____ DOB: _____ Phone: _____
Insurer_____ ID #_____ Group #_____ Provider Phone:_____

*The patient has failed at least two antidepressant medications. These medications are:*

| Medication | Maximum Dosage | Dates of Trial |
|---|---|---|
| | | |
| | | |
| | | |

*Please provide the following contact information if applicable (required for certain insurers):*

| | Name | Phone Number |
|---|---|---|
| Prescriber: | | |
| Current or past therapist: | | |

I understand that Polaris Psychiatry exclusively provides TMS services, and **not** ongoing psychiatric care, medication management, or medication refills. Further, while patients will be screened for safety concerns, suicidal ideation and other issues that may arise **must** be managed by their referring physician.

_____ _____ _____ _____
MD Signature MD Printed Name Date Time

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***The below section is only for Primary Care Physicians.***

**Through my signature below, I certify that the patient is medically cleared for TMS, and that**

1. The patient does not have metallic objects or ferromagnetic medical implants (including certain hearing implants) in their head or neck (dental fillings are safe).
2. The patient does not have a known seizure disorder, and has never had a seizure.
3. The patient has not been diagnosed with bipolar disorder, schizoaffective disorder, or schizophrenia, as TMS can worsen mania, paranoia, delusions, and hallucinations.

_____ _____ _____ _____
MD Signature MD Printed Name Date Time