McLean HOSPITAL
HARVARD MEDICAL SCHOOL AFFILIATE

Transcranial Magnetic Stimulation (TMS) Clinician Referral Form

Patient Name: ______________________________ **Date:** ____________

DOB: ____________________ **Phone:** ______________________________

Address: ____

Insurance: ____

Diagnosis, estimated length of duration current episode of depression, and reason for referral:

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Current medical conditions:

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All current medications (for psychiatric or other medical conditions) and doses:

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Medication trials during current episode of depression: Please include dose, duration, dates and response for each medication.

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Psychotherapy trials:

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Physician Name: ____

Address: ____

Phone: ________________ **Fax:** ________________ **Email:** ______________________

A completed referral form is required before a patient may complete his/her first TMS visit. If you have any questions regarding TMS, please call 617.855.2360.

Please fax the completed form to 617.855.3266 or mail to McLean Hospital, Attn: TMS Department, 115 Mill Street, Belmont, MA 02478.