TMS REFERRAL FORM

Send completed form to:

Email: patients@matthewbergermd.com **| Fax: (570) 207-0615**

Offices of Psychiatry & Counseling Services
Matthew A. Berger, MD, PC

REFERRAL SOURCE INFORMATION

Provider: | NPI: | Phone: | Fax:

Practice: | Address: | Email:

PATIENT INFORMATION

Patient: | Age: | DOB: MM DD YYYY

Address: | Phone:

Gender: ☐ Female ☐ Male **INSURANCE:** Primary: | Secondary:

Current diagnosis code:

Current medications:

TMS AUTHORIZATION QUESTIONS

1. Was the member's diagnosis determined by a face-to-face evaluation by a psychiatrist? ☐ Yes ☐ No

Name of psychiatrist: | Evaluation date: MM DD YYYY

2. Is there a current confirmed diagnosis of Major Depressive Disorder - Moderate or Severe? ☐ Yes ☐ No

3. Was the diagnosis validated using a diagnostic tool (for example, PHQ-9)? ☐ Yes ☐ No

☐ PHQ-9 attached | Other diagnostic tool:

4. Document the full extent of treatment failure:

Include psychotherapy dates and medication names, doses, length of trial, and results.

5. Does the member have any contraindications for TMS? ☐ Yes ☐ No

If yes, describe:

6. Has this member received TMS previously? ☐ Yes ☐ No

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PREVIOUS TMS

If yes, provide dates, location, course details, and outcome:

SCREENING QUESTIONS

Check all that apply:

METAL IN THE HEAD

- ☐ Aneurysm clips or coils
- ☐ Stents
- ☐ Cochlear implants
- ☐ Bullet fragments or shrapnel

IMPLANTED DEVICES

- ☐ Pacemaker
- ☐ Vagus nerve stimulator
- ☐ Deep brain stimulator

ACTIVE BRAIN DAMAGE

- ☐ Active brain tumors
- ☐ Increased intracranial pressure

Other relevant condition, implant, or device:

ADDITIONAL INFORMATION

Please provide any additional clinical information relevant to the TMS referral:

REFERRING PROVIDER ATTESTATION

Provider name/title: Date: MM DD YYYY