TMS Service
Center for Brain Circuit Therapeutics
Patient Referral Form

Referrer Information

Name:
Profession/Specialty:
Phone:
E-Mail (optional):

Patient Information

Name:
Date of Birth:
Phone:
Insurance:
E-Mail (optional):
BWH MRN (if available):

Brief Patient Narrative

Prior and Current "Antidepressant" Trials

Please note that most insurances require ≥4 trials across ≥2 classes

Medication	Start (mm/yy)	End (mm/yy)	Max Dose	Main/Side Effects and Comments

Additional Questions

1. Has the patient had psychotherapy? Yes/No
2. Has the patient received TMS before? Yes/No
3. Does the patient have any metal in the head/neck area or implanted devices like pacemakers? Yes/No
4. Does the patient have a history of seizures? Yes/no

Comments or Concerns