Indianapolis TMS

Referral Form

11950 Fishers Crossing Drive • Fishers, IN 46038
Phone: 317•595•2171 Fax: 317•595•5554

Circle One: TMS or Spravato

❖ Referral Source Information

Referring Physician/Therapist: _____

Referral Date: _____ **Office Phone/Fax:** _____

❖ Patient Information

Name: _____ DOB:_____

Patient Address: _____

Patient Phone(s): _____ Email Address: _____

Any Known Metal in Head or Neck? _____Y _____N If yes, where? _____

Current Diagnosis: _____

Psychotropic Medication History:

Name: _____ Dose: _____ Duration:_____ Side Effect: _____
Name: _____ Dose: _____ Duration:_____ Side Effect: _____
Name: _____ Dose: _____ Duration:_____ Side Effect: _____
Name: _____ Dose: _____ Duration:_____ Side Effect: _____

Medical/Treatment History
_____
_____
_____

❖ Health Insurance Information

Insurance Provider: _____ Insurance Phone Number_____

Subscriber Name: _____ Employer: _____

Policy #: _____ Group #: _____

Please fax a copy of the insurance card (front and back) with this form along with any medical records related to Medication History

❖ **Please fax completed form to 317•595•5554**