Patient Referral Form

If you feel your patient could benefit from TMS Therapy, please fax the completed form with any relevant clinical information to: **(502) 792-7292**

Patient Name: ______________________ Phone #: ______________

Address: ____

Date of Birth: ______________ Insurance Provider: ______________

Insurance Phone #: _________ Policy Number/ID: ______________

Referring Provider: ____

Address: ____

Office Phone #: ______________ Office Fax: __________________

Have you discussed TMS as a treatment option with the patient? ☐ Y ☐ N

Does the patient have one of the following ICD-10 Diagnosis codes?

☐ F32.2 ☐ F33.2 ☐ Other Diagnosis Code ______________

Additional Notes: ____

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100 Mallard Creek Road | Phone: (502) 742-8182 | Fax: (502) 792-7292 | info@tmsoflouisville.com