Northern TMS
TRANSCRANIAL MAGNETIC STIMULATION

Dear Doctor,

Thank you for contacting Northern TMS regarding treatment with Transcranial Magnetic Stimulation (TMS) for Major Depression on behalf of your patient.

*Detailed clinical information is needed in order to complete a patient evaluation, including determination of appropriateness for TMS therapy and eligibility for coverage by health insurance. Please complete the referral in full and attach a recent PHQ-9, MADRS, and/or IDSSR screening.*

There are specific TMS parameters to ensure safety and eligibility. Below are general TMS insurance guidelines and exclusions.

Guidelines:

- A primary diagnosis of Major Depressive Disorder, Recurrent, Severe
- Resistance to treatment as evidenced by a lack of clinically significant response to four trials of pharmacologic agents in the current depressive episode, from at least two different agent classes OR inability to tolerate four agents from two different agent classes with distinct side effects
- Trial of evidenced based pyschotherapy known to be effective in the treatment of MDD of an adequate frequency and duration without significant improvement in depressive symptoms as documented by standardized rating scales that reliably measure depressive symptoms

Exclusions:

- The patient has been diagnosed with Schizophrenia, Schizophreniform Disorder, Schizoaffective Disorder or Bipolar Disorder
- There is a presence of psychotic symptoms in the current depressive episode
- There are neurological conditions that include Epilepsy, Parkinson's disease, Multiple Sclerosis, Cerebrovascular disease, Dementia, increased cranial pressure, having a history of repetitive or severe head trauma, primary or secondary tumors in the CNS or any degenerative neurological condition

*Please note Medicaid and PMAP plans do not recognize TMS treatment and do not cover the procedure. If you have any questions about the above guidelines or exclusions, please call* ***Kristi Zernov, TMS coordinator, at 218.454.4386****.*

Northern TMS offers consultative and procedural services only. If the patient is accepted for TMS treatments, transfer of care will return to you, their primary provider, after TMS course completion.

Thank you very much for your help with this process. Do not hesitate to contact us with any questions or concerns. We look forward to working with you on your patient's behalf.

Sincerely,

Northern TMS
TMS Scheduling Phone 218.454.4386
TMS Scheduling Fax 218.454.0091

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Date of Referral: _____

| PATIENT INFORMATION | PHYSICIAN INFORMATION: |
|---|---|
| Name:_____ | Name:_____ |
| DOB:_____ | Phone Number:_____ |
| Phone Number:_____ | Fax Number:_____ |
| Insurance:_____ | |
| Group #:_____ ID # _____ | |

**Primary Diagnosis**:_____ **ICD-10 Code**:_____

**Additional Diagnosis**:_____ **ICD-10 Code**:_____

| **Please check "Yes" or "No" to the following (all questions MUST be answered):** | **Yes** | **No** |
|---|---|---|
| 1. Does the patient have a history of psychosis? | ☐ | ☐ |
| 2. Does the patient have a history of mania? | ☐ | ☐ |
| 3. Does the patient have a history of substance abuse and/or alcohol abuse? | ☐ | ☐ |
| 4. Does the patient have a history of seizures: | ☐ | ☐ |
| 5. Does the patient currently have any suicidal ideation? | ☐ | ☐ |
| 6. Has the patient ever attempted suicide? | ☐ | ☐ |

**Previous Psychiatric Inpatient AND/OR Partial Hospitalization (circle one): Yes No**

| Facility | Dates of Stay (if available) | Inpatient | Partial |
|---|---|---|---|
| | | ☐ | ☐ |
| | | ☐ | ☐ |
| | | ☐ | ☐ |

**Has patient participated in psychotherapy known to be effective in the treatment of MDD (circle one)? Yes No**

| **Type of Psychotherapy** | **Time Span** | **Outcome** |
|---|---|---|
| | | |
| | | |
| | | |

**Diagnostic tool used to support diagnosis of MDD (at least one diagnostic tool is required):**

| **Diagnostic Tool** | **Date Administered** | **Score** |
|---|---|---|
| Beck Depression Inventory II (BDI-II) | | |
| Patient Health Questionnaire (PHQ9) | | |
| Montgomery-Asberg Depression Rating Scale (MADRS) | | |
| The Inventory of Depressive Symptomatology-Self Report (ISD-SR) | | |
| Hamilton Depression Scale Rating (HAM-D) | | |
| **Other:** | | |

**Please list OR include a copy of current medications:**

| **Current Medication(s):** | **Dose** | **Date Initiated** |
|---|---|---|
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**Previous Neuromodulation**

| Yes | No | Item | Outcome |
|---|---|---|---|
| ☐ | ☐ | **Previous ECT** | |
| ☐ | ☐ | **Previous TMS** | |

**Metals Screen**

| Yes | No | Item |
|---|---|---|
| ☐ | ☐ | **Implanted or lodged metals in body** |
| ☐ | ☐ | **Implanted surgical devices** |
| ☐ | ☐ | **Metal-containing facial or scalp tattoos** |
| ☐ | ☐ | **Non-removable piercings** |

**Seizure Screen**

| Yes | No | Item |
|---|---|---|
| ☐ | ☐ | **Current Seizure Disorder** |
| ☐ | ☐ | **History of Seizure** |

**Does patient have a cochlear implant? _____**

**Does patient have any shunts? _____**

**Does patient have a pacemaker? _____**

**Does patient have a vagus nerve stimulator? _____**

**Does patient have a deep brain stimulator? _____**

**Any other implanted device? _____**

**Additional Studies (Please send full reports of additional studies)**

| Yes/No | Modality | Brief Results |
|---|---|---|
| | **EEG** | |
| | **Neurology/Neuropathy** | |

## ***Medication Trials: Please check all that apply:***

| Medication | Duration | Max Dose | Reason for DC<br>*Ineffective (Ineff)<br>Intolerable (Intol)<br>Self-discontinued (Self) |
|---|---|---|---|
| Citalopram | | | ☐Ineff ☐Intol ☐Self |
| Escitalopram | | | ☐Ineff ☐Intol ☐Self |
| Fluoxetine | | | ☐Ineff ☐Intol ☐Self |
| Fluvoxamine | | | ☐Ineff ☐Intol ☐Self |
| Paroxetine | | | ☐Ineff ☐Intol ☐Self |
| Sertraline | | | ☐Ineff ☐Intol ☐Self |
| Desvenlafaxine | | | ☐Ineff ☐Intol ☐Self |
| Duloxetine | | | ☐Ineff ☐Intol ☐Self |
| Levomilnacipran | | | ☐Ineff ☐Intol ☐Self |
| Venlafaxine | | | ☐Ineff ☐Intol ☐Self |
| Amitriptyline | | | ☐Ineff ☐Intol ☐Self |
| Clomipramine | | | ☐Ineff ☐Intol ☐Self |
| Desipramine | | | ☐Ineff ☐Intol ☐Self |
| Doxepin | | | ☐Ineff ☐Intol ☐Self |
| Imipramine | | | ☐Ineff ☐Intol ☐Self |
| Marprotiline | | | ☐Ineff ☐Intol ☐Self |
| Nortriptyline | | | ☐Ineff ☐Intol ☐Self |
| Rasagiline | | | ☐Ineff ☐Intol ☐Self |
| Bupropion | | | ☐Ineff ☐Intol ☐Self |
| Vilazodone | | | ☐Ineff ☐Intol ☐Self |
| Vortioxetine | | | ☐Ineff ☐Intol ☐Self |
| Chlorpromazine | | | ☐Ineff ☐Intol ☐Self |
| Fluphenazine | | | ☐Ineff ☐Intol ☐Self |
| Haloperidol | | | ☐Ineff ☐Intol ☐Self |
| Perphenazine | | | ☐Ineff ☐Intol ☐Self |
| Risperidone | | | ☐Ineff ☐Intol ☐Self |
| Ziprasidone | | | ☐Ineff ☐Intol ☐Self |
| Aripiprazole | | | ☐Ineff ☐Intol ☐Self |
| Brexpiprazole | | | ☐Ineff ☐Intol ☐Self |
| Lurasidone | | | ☐Ineff ☐Intol ☐Self |
| Olanzapine | | | ☐Ineff ☐Intol ☐Self |
| Quetiapine | | | ☐Ineff ☐Intol ☐Self |

| Medication | Duration | Max Dose | Reason for DC<br>*Ineffective (Ineff)<br>Intolerable (Intol)<br>Self-discontinued (Self) |
|---|---|---|---|
| Carbamazepine | | | ☐Ineff ☐Intol ☐Self |
| Lamotrigine | | | ☐Ineff ☐Intol ☐Self |
| Lithium | | | ☐Ineff ☐Intol ☐Self |
| Oxcarbazepine | | | ☐Ineff ☐Intol ☐Self |
| Topiramate | | | ☐Ineff ☐Intol ☐Self |
| Valproate | | | ☐Ineff ☐Intol ☐Self |
| Isocarboxazid | | | ☐Ineff ☐Intol ☐Self |
| Phenelzine | | | ☐Ineff ☐Intol ☐Self |
| Rasagiline | | | ☐Ineff ☐Intol ☐Self |
| Selegiline | | | ☐Ineff ☐Intol ☐Self |
| Tranylcypromine | | | ☐Ineff ☐Intol ☐Self |
| Amphetamine | | | ☐Ineff ☐Intol ☐Self |
| Atomoxetine | | | ☐Ineff ☐Intol ☐Self |
| Dextroamphetamine | | | ☐Ineff ☐Intol ☐Self |
| Lisdexamphetamine | | | ☐Ineff ☐Intol ☐Self |
| Methylphenidate | | | ☐Ineff ☐Intol ☐Self |
| Pemoline | | | ☐Ineff ☐Intol ☐Self |
| Alprazolam | | | ☐Ineff ☐Intol ☐Self |
| Clonazepam | | | ☐Ineff ☐Intol ☐Self |
| Diazepam | | | ☐Ineff ☐Intol ☐Self |
| Eszopiclone | | | ☐Ineff ☐Intol ☐Self |
| Lorazepam | | | ☐Ineff ☐Intol ☐Self |
| Oxazepam | | | ☐Ineff ☐Intol ☐Self |
| Temazepam | | | ☐Ineff ☐Intol ☐Self |
| Triazolam | | | ☐Ineff ☐Intol ☐Self |
| Zaleplon | | | ☐Ineff ☐Intol ☐Self |
| Zolpidem | | | ☐Ineff ☐Intol ☐Self |

**Augmentation Strategies**

| Combination | Duration | Max Dose | Reason for DC |
|---|---|---|---|
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**Additional Medication Trials (if applicable)**

| Medication | Duration | Max Dose | Reason for DC |
|---|---|---|---|
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***Please note any additional information:***