LA TMS
Los Angeles TMS Institute

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PHYSICIAN REFERRAL FORM

From: _____

Address _____

City/State _____ Zip _____

phone _____ fax _____

Referring Physician's NPI # _____

Patient being referred:

Name _____

Date of Birth _____ phone _____

Diagnosis:

- ☐ Major Depressive Disorder: ☐ single episode ☐ recurrent
- ☐ Dysthymic Disorder
- ☐ Depressive Disorder Not Otherwise Specified
- ☐ Bipolar Disorder, currently depressed
- ☐ other (specify): _____

Referral is for:

- ☐ evaluate for treatment with Transcranial Magnetic Stimulation (TMS)
- ☐ evaluate for treatment with Ketamine
- ☐ Second Opinion Consultation
- ☐ other (specify): _____

Physician Signature: _____ date _____

Please fax this form to 310-455-6098.
We will then call your patient at the number you indicated to schedule an appointment and coordinate sending us medical records.