

**Phone: 205-523-5618**  **Fax: 659-210-3460**

*Please Print Legibly* Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: Male Female PCP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_apt/lot/unit #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please send Copy of Insurance card (Front & Back)**

Insurance (primary):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance (secondary):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Doctor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referring email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_Physician Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referral To:**

**Department (Circle One): Neurology | Psychiatry | TMS**

***Transcranial Magnetic Stimulation (TMS) is FDA approved and covered by all major insurance and Medicare for the treatment of major depressive disorder and other psychiatric and neurological conditions for patients age 18 years or older. An initial regime (i.e. 30-36 treatments) is administered by Novus in outpatient office setting if individual meets criteria.***

Does the patient have one of the following ICD-10 Diagnosis Codes? F32.2 or F33.2

The requirements for medication trails differ between insurances but 2-4 failed Antidepressants with its classification (i.e. SSRI, SNRI, TCA, MAOI, other).Please list prior or current medications including max doses, approximate dates of therapy, and any side effects that the patient experienced \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Current Levels of Impairment (work, school, social, sleep, mood, etc) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has the patient tried at least one course of psychotherapy?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any prior ECT or TMS Treatments? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any history of seizures? \_\_\_\_\_\_\_\_\_\_\_\_ Diagnosis of biopolar disorder?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any non-removable metal objects in or near head?\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Electronic implants:\_\_\_\_\_\_\_\_\_

Any Active Neurological Disorder or Psychotic Symptoms?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please send records and insurance referral (if required) along with this referral. Appointment will not be made until records and insurance referral are received.**

**Internal Use FAXED:\_\_\_\_\_\_\_\_\_\_\_\_**

Scheduled Appointment Time: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ @\_\_\_\_\_\_:\_\_\_\_\_\_ w/Dr.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pt Notified \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ @\_\_\_\_\_:\_\_\_\_\_\_ by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_