Guadalupe Psychiatry and Mental Health Services
Transcranial Magnetic Stimulation Self-Referral
Fax to: (505)792-6060

Date Submitted: ____/____/____

Patient Information

Patient's Name:_____

Patient's Phone Number:_____

Patient's email:_____

Sex: □ M □ F

Date of Birth:_____

Insurance Information (Submit Copy of Insurance Card)

Primary Insurance Company Name:_____

Insurance Phone Number:_____

Plan Type: ☐ HMO ☐ PPO □ Commercial ☐ Medicare ☐ Medicaid

Member ID Number: _____

Group Number: _____

Policy Holder:_____

Policy Holder Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

PLEASE ATTACH A COPY OF BOTH SIDES OF THE PATIENT'S INSURANCE CARD

Medical History:_____

Pharmacotherapy History

Most payers require clearly documented antidepressant treatment history to show the patient has failed to respond to at least four (4) drug trials or could not tolerate four medication trails due to side effects.

1-_____

2-_____

3-_____

4-_____

ECT History

Has the patient been treated with ECT in a previous depressive episode? □Yes □No.

If yes, was the treatment successful? □Yes □No

Has the patient been treated with ECT in the current episode? □Yes □No

Has the patient been treated for depression with TMS in a previous depressive episode? □Yes □No

If yes, what system? □ Neurostar □Brainsway

No. of sessions _____

General Medical Condition Questionnaire

Are any of the following conditions present in the patient?

Check all relevant:

□ recently attempted suicide or suicidal ideation

□ has acute or chronic psychotic symptoms or disorders (e.g.,

schizophrenia, schizophreniform or schizoaffective disorder) in

the current depressive episode

□ has bipolar disorder

□ has a history of substance abuse or has used alcohol or

illicit substances excessively in the last 30 days

□ has a history of obsessive compulsive disorder (OCD) or posttraumatic

stress disorder (PTSD)

□ has major depressive disorder with psychotic features

□ has neurological conditions that include epilepsy history, cerebrovascular disease, dementia, increased intracranial pressure, repetitive or severe head trauma, or primary or secondary tumors in the central nervous system

□ has metal implants in or around the head

□ has a Vagus Nerve Stimulator (VNS) or other implant controlled by physiologic signals (such as pacemakers, implantable cardioverter defibrillators)

□ is pregnant or nursing

Please also complete the PHQ-9 form and fax together with this form.

If you do not have a fax mail the form to:

GPMHS

1350 Jackie Road SE

Suite 104

Rio Rancho, NM 87124