LA TMS
Los Angeles TMS Institute

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PHYSICIAN REFERRAL FORM

From: _____

Address _____

City/State _____ Zip _____

phone _____ fax _____

email _____

Referring Physician's NPI # _____

Patient being referred:

Name _____

Date of Birth _____

phone _____

email _____

Diagnosis:

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

Referral is for:

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

Physician Signature: _____ date _____

Please fax this form to 833-814-2558
We will then call your patient at the number you indicated
to schedule an appointment and coordinate sending us medical records.