Transcranial Magnetic Stimulation (TMS) - Initial Request

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TMS Coordinator Information

TMS Coordinator Name:*

TMS Coordinator Contact #:* ___-___-____

TMS Coordinator E-mail:*

Is this a telephonic request (INTERNAL OPTUM USE ONLY)?**
◯ Yes ◉ No

Psychiatrist & Provider Contact Information

Ordering Psychiatrist Name:*

Ordering Psychiatrist Contact #:* ___-___-____

Tax ID # for TMS Services:*

Servicing Address:

Treatment Information

I confirm the participant is at least 18 years of age or older.*
☐

Which Device will be used?*

Is this an FDA approved device?**
◯ Yes ◯ No

Is this Device FDA approved for treatment of Major Depressive Disorder?**
◯ Yes ◯ No

Has the ordering psychiatrist examined the participant and reviewed the record?**
◯ Yes ◯ No

Does the ordering psychiatrist have experience in administering TMS therapy?**
◯ Yes ◯ No

Will the treatment be given under the direct supervision of this psychiatrist?**
◯ Yes ◯ No

Specify Algorithm Used:**
◯ STAR*D ◯ TMAP

Date of onset of current episode of major depression?*
__/__/____

Treatment History

Has participant received prior rTMS at anytime for Major Depressive Disorder?**
○ Yes ○ No

Is the participant currently admitted to a level of care other than outpatient?**
○ Yes ○ No

Diagnosis Information

Diagnosis (Please include ALL psychiatric diagnosis(s) based on your evaluation and information from the referring provider):*

Validation Rating Scales to Support Diagnosis of Major Depression:

Major Depression Validation Tool Used:* --SelectOne--

Date Administered:* __/__/____

Score*

Additional tools used to validate MDD diagnosis?
○ Yes ○ No

Which tool used at baseline screening will be used weekly throughout TMS?*

Medication Trials

Medication #1* | Dose:* | Start Date:* __/__/____ | End Date:* __/__/____ | Discontinued? ☐ | Episode: ○ Current Episode ○ Lifetime

Medication #2* | Dose:* | Start Date:* __/__/____ | End Date:* __/__/____ | Discontinued? ☐ | Episode: ○ Current Episode ○ Lifetime

Additional information regarding medication trials:

Additional Clinical Information

Does the participant have a suicide plan or recent suicide attempt?**
○ Yes ○ No

Does the patient have a psychiatric emergency where a rapid clinical response is needed, such as marked physical deterioration or catatonia?**
○ Yes ○ No

Does the participant have a history of any of the following conditions?

Obsessive Compulsive Disorder
☐

Psychotic Disorder, Including Schizoaffective Disorder?
☐

Bipolar Disorder
☐

Bipolar Disorder
☐

Does the participant have a history of the following conditions in the past year?

Substance Abuse
☐

Post-traumatic Stress Disorder (PTSD)
☐

Eating Disorder
☐

Has the participant been diagnosed with any other neurological conditions? (history of or risk factors for Seizures, stroke, chronic pain, Alzheimer's, dementia, autism and psychotic disorders (including major depression with psychotic features and schizoaffective disorder).**
○ Yes ○ No

Is the participant pregnant or nursing?**
○ Not Applicable ○ Yes ○ No

Is the participant concurrently taking medications such as tricyclic antidepressants, neuroleptic/antipsychotic medications (e.g., clozapine), or other drugs that are known to lower the threshold for seizures (e.g., cocaine and other CNS stimulants)?**
○ Yes ○ No

Does the participant have a secondary condition that may significantly alter electrolyte balance or lower seizure threshold (e.g., epilepsy, stroke, dementia, head trauma)?**
○ Yes ○ No

Does the participant have metal in or around the head?**
○ Yes ○ No

Does the patient have a Vagus Nerve Stimulator or Implants controlled by physiologic signals? (Examples could include pacemakers, implantable cardioverter defibrillators)?**
○ Yes ○ No

I hereby attest that all of the information above is true and accurate to the best of my knowledge.*
☐

Submitter's Name:* Submitter's E-mail Address:*

Data Capture Required:
○ Yes