UMassMemorial Medical Group

Referral Form

Center for Neuromodulation / Department of Psychiatry

Electroconvulsive Therapy (ECT), Transcranial Magnetic Stimulation (TMS)

Phone: 508-334-1055 Fax: 774-441-6072

Email: Neuromodulation@umassmemorial.org

Web: https://www.umassmed.edu/psychiatry/clinicalservices/CenterforNeuromodulation

Instructions: Indicate below all information about your patient. Please complete and fax clinical notes, to include psychiatric evaluation/Psych HPI, medical HPI assessment, 2 – 3 recent progress notes along with any recent labs and all clinical scales (including PHQ9, etc). Please include past ECT, TMS, or Esketamine notes if applicable.

REFERRING PHYSICIAN:

Name: _____ Agency: _____

Phone: _____ Fax: _____

PATIENT INFORMATION:

Name: _____ Date of Birth: _____

Address: _____

Cell Phone: _____ Home phone: _____

Insurance and Identification #: _____

PSYCHIATRIC DIAGNOSIS: Please include ALL psychiatric diagnosis(s) based on your evaluation and information from the referring provider. Include which validation rating scales were used to support diagnosis of major depression (at least one is required and must be faxed). _____

_____

MEDICAL CONDITION(S): _____

MEDICATION TREATMENT HISTORY (current and past): Please include dosage, efficacy, side effects, reason for discontinuation. Please also include augmenting agents.

Medication	Dose	Start Date	End Date	Reason for Discontinuing

TREATMENT HISTORY:

Please list type of Therapy: Provider Giving Treatment: Frequency:

_____

History of seizures? Yes or No Current status:

History of substance use? Yes or No Current status:

Any ferromagnetic metals in and or around the head? Yes or No

Previous TMS, ECT or Esketamine treatment? Yes or No

If yes, when, and where was the last treatment? _____