PrairieCare medical group

Edina Center for Neurotherapeutics
6363 France Ave S. Suite 212
Edina, MN 55435

Dear Doctor:

Thank you for contacting PrairieCare Medical Group's Center for Neurotherapeutics (CFN) regarding treatment with **Transcranial Magnetic Stimulation (TMS) for Major Depression** on behalf of your patient.

Detailed clinical information is needed in order to complete a patient evaluation, including determination of appropriateness for TMS therapy and eligibility for coverage by health insurance. Please complete the referral in full and fax to 952-920-0877.

There are specific TMS parameters to ensure safety and eligibility. Below are general TMS guidelines and exclusions.

Guidelines:

- A primary diagnosis of Major Depressive Disorder, Recurrent, Severe
- Resistance to treatment as evidenced by a lack of clinically significant response to four trials of pharmacologic agents in the current depressive episode, from at least two different agent classes **OR** inability to tolerate four agents from two different agent classes with distinct side effects
- Trial of evidenced based psychotherapy known to be effective in the treatment of MDD of an adequate frequency and duration without significant improvement in depressive symptoms as documented by standardized rating scales that reliably measure depressive symptoms

Exclusions:

- The patient has been diagnosed with Schizophrenia, Schizophreniform Disorder, Schizoaffective Disorder or Bipolar Disorder
- There is a presence of psychotic symptoms in the current depressive episode
- There are neurological conditions that include Epilepsy, Parkinson's disease, Multiple Sclerosis, Cerebrovascular disease, Dementia, increased cranial pressure, having a history of repetitive or severe head trauma, primary or secondary tumors in the CNS, or any degenerative neurological condition

If the patient is accepted for TMS treatment, transfer of care will return to you, their primary provider, after TMS course completion.

Thank you very much for your help with this process. If you have any questions about insurance coverage, guidelines, or exclusions please call the TMS Care Coordinator at 952-737-4510. We look forward to working with you on your patient's behalf.

Sincerely,

PrairieCare Center for Neurotherapeutics

PrairieCare medical group

TMS Scheduling Phone: 952-737-4510
TMS Scheduling Fax: 952-920-0877

Date of Referral: ___________________________________

Patient Information	**Psychiatrist Information**	**Therapist Information**
Name: DOB: Phone Number: Address: Email:	Name: Phone Number: Fax Number: Facility:	Name: Phone Number: Fax Number: Facility:

Primary Diagnosis: __________________________________ **ICD-10 Code** ____________________________

Additional Diagnosis: ________________________________ **ICD-10 Code:** ___________________________

Please Check "Yes" or "No" To The Following (all questions MUST be answered):	**Yes**	**No**
1. Does the patient have a history of psychosis?		
2. Does the patient have a history of mania?		
3. Does the patient have a history of substance abuse and/or alcohol abuse?		
4. Does the patient have a history of seizures?		
5. Does the patient currently have any suicidal ideation?		
6. Has the patient ever attempted suicide?		

Previous Psychiatric Inpatient AND/OR Partial Hospitalization: ☐Yes ☐No ***If yes, answer the following questions:***

Facility	**Dates of Stay (if available)**	**Inpatient**	**Partial**

Has patient participated in psychotherapy known to be effective in the treatment of MDD? ☐Yes ☐No

Type of Psychotherapy, Location, Provider Name	**Time Span**	**Outcome**

Diagnostic tool used to support diagnosis of MDD (at least one diagnostic tool is required):

Diagnostic Tool	**Date Administered**	**Score**
Beck Depression Inventory II (BDI-II)		
Patient Health Questionnaire (PHQ9)		
Montgomery-Ǎsberg Depression Rating Scale (MADRS)		
The Inventory of Depressive Symptomatology – Self Report (IDS-SR)		
Hamilton Depression Rating Scale (HAM-D)		
Other:		

Prior TMS for Major Depressive Disorder? ☐Yes ☐No ***If yes, answer the following questions:***

Diagnostic Tool Used	**Date Administered Pre TMS**	**Initial Score Pre TMS**	**Date Administered Post TMS**	**Subsequent Score Post TMS**

Prior ECT for Major Depressive Disorder? ☐Yes ☐No ***If yes, answer the following questions:***

Date Administered	Number of Treatments	Side Effects, if any	Successful Yes/No

*****Please include a copy of current medications:***

Medication Trials: Please complete all sections of this form

Medication	Start & End Date	Max Dose	State Reason for DC	Medication	Start & End Date	Max Dose	State Reason for DC
Celexa				Abilify			
Lexapro				Seroquel			
Paxil				Zyprexa			
Zoloft				Risperdal			
Prozac				Invega			
Luvox				Geodon			
Cymbalta				Rexulti			
Effexor				Latuda			
Pristiq				Lithium			
Fetzima				Lamictal			
Wellbutrin				Tegretol			
Viibryd				Trileptal			
Brintellix				Topamax			
Remeron				Depakote			
Elavil				Neurontin			
Anafranil				Amphetamine			
Norpramin				Dexadrine			
Silenor				Vyvanse			
Tofranil				Ritalin			
Teva-Maprotiline				Straterra			
Pamelor				Xanax			
Nardil				Ativan			
Azilect				Klonopin			
Marplan				Valium			
Parnate				Oxazepam			
Emsam				Restoril			
Thorazine				Halcion			
Prolixin				Lunesta			
Haldol				Sonata			
Orap				Ambien			
Trilafon							

Augmentation Strategies				Additional Medication Trials			
Combination	Start & End Date	Max Dose	Reason for DC	Medication	Start & End Date	Max Dose	State Reason for DC

Please note any additional information: