Eastside TMS & Wellness Center

15 South Grady Way, Suite 625, Renton, WA 98057
Phone: (425) 919-6826 Fax: (425) 523-1061
www.eastsidetmswellness.com

- Referral for Transcranial Magnetic Stimulation therapy

❖ Referral Source Information

Referring Physician/ Therapist:_____
Referral Date: _____
Office Phone/Fax: _____

❖ Patient Information

Name: _____
DOB: _____
Patient Address: _____
Patient Phone(s): _____
Any Known Metal in Head or Neck? _____Y _____N If yes, where? _____
Current Diagnosis: _____
Current Depressive Episode Start Date: __/__/__
Cognitive Behavorial Therapy Duration: __/__/__ - _____

Psychotropic Medication History:
Name: _____ Dose: _____
Duration: __/__/__-__/__/__
Name: _____ Dose: _____
Duration: __/__/__-__/__/__
Name: _____ Dose: _____
Duration: __/__/__-__/__/__
Name: _____ Dose: _____
Duration: __/__/__-__/__/__

Brief Medical History & Special Needs:
_____
_____

❖ Thank you very much for your referral

Please fax completed form to 425•523•1061