Wyoming Behavioral Institute
OUTPATIENT AND TELEHEALTH CLINIC

Referral for TMS and Screening Questionnaire

Patient Name: _____ DOB: _____ Male☐ Female☐

Mailing Address: _____

Phone #: _____ Email: _____

Referring Practice and Provider: _____

Diagnosis
☐ Major Depressive Disorder, recurrent, severe, F33.2
☐ Major Depressive Disorder, recurrent, severe, with psychotic features, F33.3
☐ Other_____

Score of most recent depression screening and _____

Was there a lack of response to 1 trial of psychopharmacologic agents from at least 2 different agent classes? (Please attach full medication history)

Medication and Dose	Start Date	Stop Date	Why stopped

Name of therapy provider: _____
Dates of Treatment: _____
Treatment modality: CBT____ DBT____ EMDR_____ Other_____

Has the patient been successfully treated with TMS in the past? Yes☐ No☐
Dates of treatment: _____

Screening Questionnaire: Before the patient can receive TMS treatment, we need to ensure that it is safe to do so. We will need information about the possible risk factors that could enhance the patient's risk to experience unintentional adverse effects.

1. Do you have epilepsy? Yes☐ No☐
   If yes, please specify: _____
2. Have you ever had a convulsion or a seizure? Yes☐ No☐
   If yes, please specify: _____

3. Does someone in your family have epilepsy? Yes☐ No☐
   If yes, please specify: _____

4. Have you ever lost consciousness without any known reason? Yes☐ No☐
   If yes, please describe when and how this occurred: _____

5. Have you ever had a severe head trauma/injury? Yes☐ No☐
   If yes, please specify: _____

6. Have you ever had a stroke? Yes☐ No☐
   If yes, please specify: _____

7. Have you ever undergone surgery to your head? Yes☐ No☐
   If yes, please specify: _____

8. Do you have any of the following implants in your body?
   Metal plates and/or screw Yes☐ No☐
   Vascular clips Yes☐ No☐
   Artificial heart valve Yes☐ No☐
   Metallic splinters/shrapnel/etc. Yes☐ No☐
   Pacemaker Yes☐ No☐
   Insulin pump Yes☐ No☐
   Internal hearing aid (cochlear implant Yes☐ No☐
   Any other implant not mentioned above Yes☐ No☐
   If yes, please specify: _____

9. Do you have any deviations of the spinal cord, bone marrow, or the ventricle system?
   (Spaces in the brain filled with liquid) Yes☐ No☐
   If yes, please specify: _____

10. Do you have any hearing disabilities or ringing in your ears? Yes☐ No☐
    If yes, please specify: _____

11. Have you ever suffered from a brain-related, neurological illness? Yes☐ No☐
    If yes, please specify: _____

12. Do you suffer from frequent and severe headaches? Yes☐ No☐
    If yes, please describe frequency: _____

13. Are you currently under any form of medical treatment Yes☐ No☐
    If yes, please specify: _____

14. Are you currently taking antibiotics? Yes☐ No☐
If yes, please specify: _____

15. Do you ever take antihistamines? Yes☐ No☐
If yes, please specify: _____

16. Are you currently taking any other medications not mentioned above? Yes☐ No☐
If yes, please specify: _____

17. Do you have a chronic illness/disorder? Yes☐ No☐
If yes, please specify: _____

18. Does someone in your family have a psychiatric condition? Yes☐ No☐
If yes, please specify: _____

19. Have you used any recreational drugs during the past year? Yes☐ No☐
If yes, please specify: _____

20. Have you ever suffered from substance dependence or abuse? Yes☐ No☐
If yes, please specify: _____

21. Do you consume 3 or more alcoholic beverages per day? Yes☐ No☐

22. Do you have issues with sleep? Yes☐ No☐
If yes, please specify: _____

23. Are you pregnant or is there a chance that you might be? Yes☐ No☐

24. If you have ever undergone an MRI, did any problems occur during scan? Yes☐ No☐
If yes, please specify: _____

I have screened this patient for all possible benefits, risks, and potential contraindications and am referring them for TMS treatment.

Referring Provider Signature: _____ Date: _____

Printed Name: _____

*****To expedite the insurance approval process, please attach patient's insurance information as well as any progress notes that help support medical necessity and fax to 307-237-2166**