TMS Clinical and Research Service

Provider Referral for Evaluation for Transcranial Magnetic Stimulation Treatment

760 Westwood Plaza, Los Angeles, CA 90094-1759
Phone: 310-825-7471 Fax: 310-825-7642

Date: _____/_____/_____

Patient Name:_____

Patient Phone: _____

Patient Date of Birth: _____/_____/_____

Referring Provider: _____ NPI #:_____

Provider Address: _____

City / State _____ Zip _____

Provider Phone #:_____

Provider Fax #: _____

Evaluate and Treat for:

(Please check one)

- ☐ F32.9– Major Depressive Disorder, Single Episode
- ☐ F33.9– Major Depressive Disorder, Recurrent
- ☐ F34.1– Dysthymic Disorder
- ☐ F32.9– Depressive Disorder Not Otherwise Specified
- ☐ Other (specify): _____

Additional Notes: _____

_____

_____

_____

Provider Signature: _____

If you have any questions, please email us at uclatms@mednet.ucla.edu

Please fax this form to UCLA at 310-825-7642. Thank you for referring your patient to our service. One of our staff will contact you promptly.