387 FRANKLIN ST
buffalo ny 14202
716.462.0284
716.262.0481

Transcranial Magnetic Stimulation (TMS) Direct Referral Form
Major Depressive Disorder (MDD)

Patient Information:

Full Name ____

Date of Birth _____________________

Mailing Address ____

City _____________________ State ______ Zip Code _________

Insurance Carrier ____

Member ID _________________________ Group Number ______________________

Referring Provider Information:

Referring Healthcare Provider Name ____

Provider Mailing Address ____

City _______________________________ State _______ Zip Code _________________

Phone (___) _________________ Fax (___) _________________

Medical History:

Have you ever received TMS, Spravato/esketamine, or ECT treatment in the past? ☐Yes ☐No

If yes, when did you receive this treatment? _______________ Was the treatment successful? ☐Yes ☐No

If YES, please submit this form with the following supporting documents	If NO, please submit this form with the following supporting documents
• 3 most recent TMS, esketamine or ECT appointment notes that includes approved diagnosis • PHQ9 assessment from end of previous treatment and a current PHQ9 (PHQ9 scores below 15 may not qualify) • Current medication list (including dose & duration) • Historical medication list (including dose, duration, and reason for discontinuation)	• At least 5 recent appointment notes from your current provider that clearly indicate the approved diagnosis (F33.2) • A recent PHQ9 assessment (PHQ9 scores below 15 may not qualify) • Current medication list including dose & duration • Historical medication list, including dose, duration, and reason for discontinuation (patients must have failed at least 4 drug trials prior to TMS)

Please send this completed form, along with the appropriate supporting documentation, to Landmark Health Systems.

By Mail: 387 Franklin St Buffalo NY 14202
By Fax: 716-262-0481 attn TMS Department

I attest that all the information provided is accurate and up-to-date to the best of my knowledge. I understand that submission of this information does not guarantee acceptance into the TMS program at Landmark Health Systems

Patient signature: ______________________________________ Date: ____________

Printed Name: ____ DOB: ______________

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

ID #: ______________________ DATE: ______________

Over the last *2 weeks*, how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns		+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	
	Not difficult at all ________
	Somewhat difficult ________
	Very difficult ________
	Extremely difficult ________

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