Behavioral Health Care Management
Transcranial Magnetic Stimulation (TMS) Treatment Request

Quartz
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QuartzBenefits.com

Please write clearly and legibly – complete all sections.

MEMBER INFORMATION

Name:	Date of Birth:
Quartz Insurance ID Number:	Member Phone Number:

REFERRAL SOURCE / REQUESTING PSYCHIATRIST

Provider Name:	Phone:	Fax:
Facility/Clinic Name:	Last Date Seen by Referring Provider:	

REQUESTED TREATMENT PROVIDER INFORMATION

Facility Name:	Provider Name:

Facility Address:

Contact Name:	Phone:	Fax:

DSM5 diagnosis:	Start Date of Requested Service: _____
What is the frequency (rate of magnetic pulses in Hz) being used?	Number of units/visits requested:

CPT PROCEDURE

TMS Procedure Code(s):	Description:

The current episode of depression began (MM/YY): _____

OBJECTIVE ASSESSMENT INFORMATION (PHQ-9, BDI, HAM-D, Y-BOCS, ETC)

Scale Used:

Date:

Score

PREVIOUS MEDICATION TRIALS

Medication	Dosage	Dates (mm/dd/yyyy)	Results of Medication Trial/Side Effects that limited dosing	Primary or Augmenting Medication

CURRENT MEDICATIONS & PRESCRIBER

Medication/dosage: Start date: Prescriber:	Medication/dosage: Start date Prescriber:
Medication/dosage: Start date: Prescriber:	Medication/dosage: Start date: Prescriber:

PREVIOUS TRANSCRANIAL MAGENTIC STIMULATION (TMS) TREATMENT

Has the patient ever received TMS? ☐ **YES** ☐ **NO** **If yes, how many sessions?** _____ Date Span _____ to _____
If **YES**, what type of TMS was received? (repetitive, deep, booster, maintenance, SAINT, accelerated, etc.) _____
If **YES**, provide evidence of improvement with rating scales (i.e., PHQ-9, BDI, HAM-D, etc.)
Include pre, concurrent, and post ratings/scores

(Pre) Scale Used:	Score:	Date Administered: _____
(Mid) Scale Used:	Score:	Date Administered: _____
(Post) Scale Used:	Score:	Date Administered: _____

MEDICAL INFORMATION

Does the patient have any of the following:

☐ Cochlear Implants

☐ Seizures (If **YES**, please provide additional information – how well controlled are seizures and date of last episode)

_____

☐ Substance Use (If **YES**, please provide additional info – Substance(s), frequency, amount and date of last use)

_____

☐ Deep Brain Stimulator

☐ Presence of acute or chronic psychotic symptoms within the past 6 months

☐ Any Metallic Hardware or Implanted Magnetic-Sensitive Medical Device at a distance within the electromagnetic field of the discharging coil (e.g. implanted cardioverter-defibrillator, pacemaker, metal aneurysm clips or coils)

PSYCHOTHERAPY HISTORY

Trials of Evidence-Based Psychotherapy: ☐ Yes ☐ No

Therapeutic Approach(es):

Provider(s):

Dates of Outpatient Psychotherapy:

Some plans require standardized assessment scores for therapy (i.e. PHQ-9, BDI, etc.) Please provide scores available for therapy timespan (before, during, after)