Oasis TMS

Patient Referral Form

If you feel your patient could benefit from TMS Therapy, please fax the completed form with any relevant clinical information to: **(502) 792-7292**

Patient Name: _____ Phone #: _____

Address: _____

Date of Birth: _____ Insurance Provider: _____

Insurance Phone #: _____ Policy Number/ID: _____

Referring Provider: _____

Address: _____

Office Phone #: _____ Office Fax: _____

Have you discussed TMS as a treatment option with the patient? ☐ Y ☐ N

Does the patient have one of the following ICD-10 Diagnosis codes?

☐ F32.2 ☐ F33.2 ☐ Other Diagnosis Code _____

Additional Notes: _____

_____

_____

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