Geisinger

Transcranial magnetic stimulation (TMS) request

The attending physician/treating provider must complete this form. Fax the completed form and pertinent clinical documentation to 570-214-4539. If you have questions, call 888-839-7972.

Request date: **Treatment start:**

Member information:

Name:

Health plan ID:

DOB: **Phone:**

Requesting provider:

Name:

NPI:

Address:

City: **State:** **Zip:**

Phone: **Fax:**

Contact: **Phone:**

☐ **Check here if requesting provider is the same as servicing provider**

Servicing provider:

Name:

NPI:

Address:

City: **State:** **Zip:**

Phone: **Fax:**

Contact: **Phone:**

Requested services:

☐ **90867** _____ sessions

☐ **90868** _____ sessions

☐ **90869** _____ sessions

Provide all medical, psychiatric, and substance use disorder DSM 5 diagnoses and ICD-10 codes:

Has the member failed trials with at least two psychopharmacologic agents? ☐ Yes ☐ No
If yes, list:

Medication:

Dates:

Duration:

Dose:

Medication:

Dates:

Duration:

Dose:

Medication:

Dates:

Duration:

Dose:

Medication:

Dates:

Duration:

Dose:

Medication:

Dates:

Duration:

Dose:

Or, list two trials of psychopharmacologic agents member is/was unable to tolerate at a therapeutic dose, with distinct side effects:

Medication:

Dates:

Duration:

Dose:

Medication:

Dates:

Duration:

Dose:

List all current medications (medical and psychiatric):

Medication:

Dates:

Duration:

Dose:

Medication:

Dates:

Duration:

Dose:

Medication:

Dates:

Duration:

Dose:

Medication:

Dates:

Duration:

Dose:

Medication:

Dates:

Duration:

Dose:

Medication:

Dates:

Duration:

Dose:

Medication:

Dates:

Duration:

Dose:

Describe onset of depressive disorder and nature of presentation (include past response to antidepressant medication(s).

Prior TMS treatment: ☐ Yes ☐ No

If yes, describe with dates, units, and response:

Dates:

Units:

Response:

Dates:

Units:

Response:

Dates:

Units:

Response:

Inpatient psychiatric admissions: ☐ Yes ☐ No

Facility:

Dates:

Reason:

Facility:

Dates:

Reason:

Outpatient treatment(s):

Provider:

Dates:

Modality/frequency:

Provider:

Dates:

Modality/frequency:

Provider:

Dates:

Modality/frequency:

Outpatient treatment(s):

Provider:

Dates:

Modality/frequency:

Provider:

Dates:

Modality/frequency:

Provider:

Dates:

Modality/frequency:

Document medical comorbidities:

Are there any contraindications to TMS, including cochlear implant, deep brain stimulator, vagus nerve stimulator, epilepsy, history of seizure or metallic or hardware/implanted magnetic-sensitive medical device? ☐ **Yes** ☐ **No**

Attach copies of the following supporting documents:

- Current admission psychiatric evaluation (no older than 7 days), including mini mental status exam
- Current medical history and physical (no older than 7 days)
- Current urine drug screen results