



FAX TO: 513-536-0779

**Attn: TMS Department
REFERRAL FORM FOR TMS FOR OCD**

DEMOGRAPHICS

Client's legal name: _____ D.O.B _____

Client's Preferred name: _____ Client's Pronouns: _____

Best contact number: _____ Secondary phone number: _____

Address: _____

Clients Insurance: _____ Member ID: _____

REFERRAL INFORMATION

Psychiatrist name: _____

Phone: _____ Fax: _____

Name of referring Clinician: _____

Name of OCD/ERP Therapist: _____

Phone: _____ Fax: _____

Dates of last 10 treatments with ERP therapist: _____

Diagnosis & AXIS I-V:

I. _____ II. _____ III. _____

IV. _____ V. _____

REASON FOR REFERRAL FOR CONSULTATION:

RELEVANT MEDICAL HISTORY

Please circle all that apply:

Endocrine Neurological Respiratory Cardiac Metal in Body Implantable Devices Other issues N/A

If yes, please specify:

PAST and CURRENT Medications : (doses, frequency, efficacy, and side effects):

Medication	Dates	Dosage	Duration	Outcome/ Side effects

From Patient's OP OCD/ERP Therapist:

Client is willing to engage in 29 consecutive treatments of TMS with ERP provocation Yes / No

Consent for TMS team at Lindner Center of Hope to contact OCD/ERP Therapist Yes / No

Is this a request for a retreatment course of TMS for OCD? Yes / No

Most recent YBOCS score: _____ Date administered: _____

Most recent PHQ-9 score: _____ Date administered: _____

Core Fear/ Target Symptom: _____

Obsessions	Compulsions

Examples of current ERP Assignments:

Please attach patient's most up to date hierarchy / distress scale and three most recent progress notes.

Please note: Consultations will not be scheduled without this information.