



UMN Mental Health Care
Institute for Neuromodulation

MnMOD TMS Program
5775 Wayzata Boulevard, Suite 255
St. Louis Park, MN 55416

Dear Doctor:

Thank you for contacting UMN Mental Health Care-Institute for Neuromodulation (MnMOD) regarding treatment with **Transcranial Magnetic Stimulation (TMS) for Major Depression** on behalf of your patient.

Detailed clinical information is needed in order to complete a patient evaluation, including determination of appropriateness for TMS therapy and eligibility for coverage by health insurance. Please complete the referral packet in full.

The assessment will include an outpatient consultation office visit with results sent to you and to the patient's primary care provider. MnMOD offers consultative and procedural services only. If the patient is accepted for TMS treatments, transfer of care will return to you, their primary provider, after TMS course completion.

Thank you very much for your help with this process. We will contact you within 2 weeks regarding appointment status. Do not hesitate to contact us with any questions or concerns. We look forward to working with you on your patient's behalf.

Sincerely,

MnMOD TMS Psychiatry Team
TMS Scheduling Phone 952.525.4500
TMS Scheduling Fax 952.525.1560



TO ASSIST US WITH THIS PROCESS, PLEASE SEND OR FAX THE FOLLOWING:

Patient Name: _____ DOB _____

Patient Phone: _____

Date of referral: _____

Referring physician Name: _____

Referring physician Phone#: _____

Referring physician FAX#: _____

Diagnoses (Include ICD9 Codes For Primary Diagnosis)

Primary Diagnoses	
Secondary Diagnoses	
Personality Disorders	
Hx of Psychosis, Current Status	
Hx of Substance Abuse, Current Status	

Past Suicide Attempt

Yes	No	Date(s), Description

Past Suicidal Ideation

Yes	No	Date(s), Description (intent, plan)

Current Suicidal Ideation

Yes	No	Duration, Description (intent, plan)



Previous Inpatient Hospitalization (Facility, dates of stay)

Previous Partial Hospitalization / Day Treatment (Facility, dates of participation)

Psychotherapy (Type of therapy, duration of treatment and number of sessions, outcome)

Medication Trials (Must include at least 4 full therapeutic trials. Must include 2 different classes of medications.)

Medication	Duration	Max Dose	Outcome	Reason for Discontinuation

Augmentation Strategies

Medication	Duration	Max Dose	Outcome	Reason for Discontinuation

Previous Neuromodulation

Yes	No	Item	Outcome
		Previous ECT	
		Previous TMS	

Metals Screen

Yes	No	Item
		Implanted or lodged metals in body
		Implanted surgical devices
		Metal containing facial or scalp tattoos
		Non removable piercings

Seizure Screen

Yes	No	Item
		Current Seizure Disorder
		History of Seizure

Does patient have a cochlear implant? _____

Does patient have any shunts? _____

Does patient have a pacemaker? _____

Does patient have a vagus nerve stimulator? _____

Does patient have a deep brain stimulator? _____

Any other implanted device? _____

Additional Studies (Please send full reports of all additional studies)

Yes/No	Modality	Brief Results
	EEG	
	Neurology/Neuropsychiatry	



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