MASSACHUSETTS
GENERAL HOSPITAL

Division of Neuropsychiatry and Neuromodulation
Department of Psychiatry
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REFERRAL FORM FOR TRANSCRANIAL MAGNETIC STIMULATION (TMS) CONSULTATION

Patient Name:

DOB:

MGH MRN (if applicable):

Phone Number(s):

Email Address:

Insurance Plan(s):

Psychiatrist's Name:

Psychiatrist's Phone Number:

Psychiatrist's Fax Number:

Current Medical Conditions:

Current Diagnoses (with ICD-10 Code):

Reason for Referral:

A completed referral form is required before a patient may complete their first TMS visit.
If you have any questions regarding TMS, please call 617-726-5340.
Please email the completed form to tms@mgh.harvard.edu or fax to 617-726-5760.