MASSACHUSETTS
GENERAL HOSPITAL

Division of Neuropsychiatry
and Nueromodulation
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 type(s):

_____

Psychiatrist's name and contact information:

_____

Current medical conditions:

_____

_____

Current diagnoses (with ICD-10 Code):

_____

Reason for referral:

_____

_____

_____

A completed referral form is required before a patient may complete his/her 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