

# Referral for TMS, Ketamine and /or ECT

## AT BOULDER COMMUNITY HEALTH

PHONE: 303-415-4299 | FAX: 303-441-2202

### First opinion referral for TRMD treatments

Is authorization required for the initial consult appointment?  Yes  No Auth. Ref. #:

Referring clinician name and credentials:

NPI#:

Business name and address:

Clinician phone number:

Fax:

Patient name:

DOB:

Patient phone number:

Patient email:

Patient address:

#### Mental health diagnosis: (check all that apply)

- |  |   |
|--|---|
| <input type="checkbox"/> Bipolar disorder          | <input type="checkbox"/> PTSD   |
| <input type="checkbox"/> Catatonia                 | <input type="checkbox"/> Schizophrenia / schizoaffective (treatment-resistant type) |
| <input type="checkbox"/> Major depressive disorder | <input type="checkbox"/> Treatment-resistant depression                             |
| <input type="checkbox"/> Mania                     | <input type="checkbox"/> Other: (please specify)                                    |

#### History of treatment resistance: (check all that apply)

- |  |  |                                   |
|--|--|-----------------------------------|
| <input type="checkbox"/> Greater than two failed medication trials | <input type="checkbox"/> ECT fail      | <input type="checkbox"/> TMS fail |
|  | <input type="checkbox"/> Ketamine fail |                                   |

#### Current medications: (include dosages)

#### BCH offers the following treatments. Indicate which treatment(s) you are submitting a patient referral for:

- |                              |   |                              |
|------------------------------|---|------------------------------|
| <input type="checkbox"/> TMS | <input type="checkbox"/> Ketamine infusions | <input type="checkbox"/> ECT |
|------------------------------|---|------------------------------|

#### Why is this treatment requested? (Check all that apply.)

- |  |   |
|--|---|
| <input type="checkbox"/> High acuity             | <input type="checkbox"/> Treatment resistance |
| <input type="checkbox"/> Other: (please specify) |   |

Referring clinician's signature:

Date:

Please fax pertinent clinical notes and treatment history notes to 303-441-2202