

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

Authorization required? Yes No Reference number for authorization:

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