What is Transcranial Magnetic Stimulation?

Transcranial magnetic stimulation (TMS) is an FDA approved, safe and effective treatment for psychiatric conditions including depression, anxiety associated with depression and obsessive-compulsive disorder (OCD). TMS works by using MRI strength magnetic pulses to stimulate specific regions of the brain. It is an outpatient procedure that does not affect cognition so patients can leave the session without assistance and immediately resume their daily activities.

TMS is typically recommended when other treatments, such as medications and psychotherapy, have not been helpful. Approximately 50-60% of people with medication resistant depression will experience a clinically meaningful response with 20-30% reaching full remission, meaning complete resolution of symptoms. Since TMS does not involve the use of psychiatric medications, it is also considered in individuals who have difficulties tolerating antidepressants due to side effects.

Eligibility

Major Depressive Disorder (MDD) - An individual between the ages of 18 – 68 may be eligible to receive TMS treatment for MDD if they meet the following criteria:

- Confirmed diagnosis of severe MDD, single or recurrent episode
- Has tried a course of ***evidence-based psychotherapy,*** with weekly or greater frequency for **at least 6 weeks**
- Treatment-resistance or inability to tolerate other treatments, demonstrated by at least one of the following:
    - At **least one failed medication trial in the current depressive episode;** or
    - History of **two medication trials** from **two different classes;** or
    - History of treatment with rTMS or electroconvulsive therapy (ECT)
- No significant contraindications (e.g. seizure disorder, metal devices implanted in head or neck)

Obsessive Compulsive Disorder (OCD) - An individual between the ages of 18 – 68 may be eligible to receive TMS treatment for **OCD** if they meet the following criteria:

- Confirmed diagnosis of OCD
- Has tried a course of ***evidence-based psychotherapy*** known to be effective for OCD, with weekly or greater frequency for **at least 8 weeks**
- Treatment-resistance or inability to tolerate other treatments, as demonstrated by at least one of the following:
    - At **least two failed medication trials** administered for **a minimum of 8 weeks;** or
    - History of **two medication trials** from **two different classes;** or
    - History of treatment with rTMS for OCD; or
    - Is currently taking antipsychotics, opioids, benzodiazepines, glutamatergic agents, or other agents which could be considered investigational or risky
- No significant contraindications (e.g. seizure disorder, metal devices implanted in head or neck)

To request an assessment of eligibility for TMS treatment, please complete and email the following forms to **DOP.PsychNAT@cuanschutz.edu**. Note that this content will be reviewed within a timeline that is dependent on our team's ability to schedule an appointment at the time it is received.

IF YOU ARE IN AN EMERGENCY OR REQUIRE EMERGENCY MEDICAL SERVICES, PLEASE CALL 911 OR GO TO YOUR NEAREST EMERGENCY ROOM.

IF YOU FEEL YOU ARE IN CRISIS, PLEASE CALL THE COLORADO CRISIS CENTER AT 1-844-493-8255

Anschutz Medical Campus
University of Colorado

DEPARTMENT OF PSYCHIATRY - TMS CLINIC REFERRAL FORM

Todays Date:		
Treating Clinician/Facility:		
Phone #:	NPI:	TIN:
PATIENT INFORMATION		
Last Name, First Name Middle Initial:		
Date of Birth:	Soc Sec #	
Gender:	Sex:	Marital Status
Race:	Ethnicity:	
ADDRESS		
City, State Zip Code:		
Phone #	Email:	
Some aspects of scheduling are easier to manage with a call. Please note times that you may be available via phone.		
GUARANTOR INFORMATION		
Responsible party: (List person financially responsible for services use full legal name, no nickname)		
Relationship of Guarantor to Patient:		
Date of Birth:	Sex:	Marital Status
Last Name, First Name Middle Initial:		
Address:		
City, State Zip Code:		
Phone #	Email:	
EMERGENCY CONTACT INFORMATION		
Emergency Contact Name:	Phone #:	

Relationship of Emergency Contact to Patient:		
PCP	Pharmacy Location	
INSURANCE INFORMATION		
PRIMARY INSURANCE		
Plan name:		
Subscriber Name (last, first middle initial:		
Subscriber Date of Birth:		
Relationship of Subscriber to Patient:		
Policy ID:	Group #:	Effective Date:
Claims Address:		
SECONDARY INSURANCE		
Plan name:		
Subscriber Name (last, first middle initial:		
Subscriber Date of Birth:		
Relationship of Subscriber to Patient:		
Policy ID:	Group #:	Effective Date:
Claims Address:		

Please attach a copy of your insurance card (front and back) with this form submission.

Safety Screening: Metallic and Electronic Implants

Please put a check mark in the boxes to indicate if you have any of the following implanted into your body:

- ❑ **Aneurysm clips or coils**
- ❑ **Cardiac pacemaker or wires**
- ❑ **Internal cardioverter defibrillator (ICD)**
- ❑ **Carotid or cerebral stents**
- ❑ **Deep brain stimulator**
- ❑ **Metallic devices implanted in your head**
- ❑ **Dental implants**
- ❑ **Cochlear implant/ear implant**
- ❑ **CSF (cerebrospinal fluid) shunt**
- ❑ **Eye implants**
- ❑ **Tattoo (particularly with metallic sheen)**
- ❑ **Vagus nerve stimulator (VNS)**
- ❑ **Blood vessel coil**
- ❑ **Shrapnel, bullets, pellets, BBs, or other metal fragments**
- ❑ **Wearable cartioverter defibrillator**
- ❑ **Implanted insulin pump**
- ❑ **Programmable shut or valve**
- ❑ **Hearing aid**
- ❑ **Cervical fixation device**
- ❑ **Other surgical clips, staples or sutures**
- ❑ **Wearable monitor (e.g. heart monitor)**
- ❑ **Bone growth stimulator**
- ❑ **Wearable infusion pump**
- ❑ **Radioactive seeds**
- ❑ **Portable glucose monitor**
- ❑ **Tracheostomy**
- ❑ **Cardiac stents, filters or metallic valves**
- ❑ **VeriChip microtransponder**
- ❑ **Any other metallic or electronic implants not mentioned above**

Prior Psychiatric Treatment and Medication History

Please put a check mark in the boxes to indicate which medications you have tried, taken for at least 6 weeks, and whether or not the medication was added to another.

ANTIDEPRESSANTS:

Selective Serotonin Reuptake Inhibitors	Tried?	Taken for at Least 6 weeks?	Drug added to another Or to boost effect?	Helped? Made you worse? Comments
Citalopram (Celexa)	❑	❑	❑	________________
Escitalopram (Lexapro)	❑	❑	❑	________________
Fluoxetine (Prozac)	❑	❑	❑	________________
Fluvoxamine (Luvox)	❑	❑	❑	________________
Paroxetine (Paxil)	❑	❑	❑	________________
Sertraline (Zoloft)	❑	❑	❑	________________
Vilazodone (Viibryd)	❑	❑	❑	________________
Serotonin-Norepinephrine Reuptake Inhibitors				
Desvenlafaxine (Pristiq)	❑	❑	❑	________________
Duloxetine (Cymbalta)	❑	❑	❑	________________
Levomilnaciprine (Fetzima)	❑	❑	❑	________________
Venlafaxine (Effexor)	❑	❑	❑	________________
Vortioxetine (Trintellix)	❑	❑	❑	________________
Tricyclic Antidepressants				
Amitriptyline (Elavil)	❑	❑	❑	________________
Clomipramine (Anafranil)	❑	❑	❑	________________
Desipramine (Norpramin)	❑	❑	❑	________________
Doxepin (Sinequan)	❑	❑	❑	________________
Imipramine (Tofranil)	❑	❑	❑	________________
Nortriptyline (Pamelor)	❑	❑	❑	________________

Protriptyline (Vivactil)	❑	❑	❑	

	Tried?	Taken for at Least 6 weeks?	Drug added to another Or to boost effect?	Helped? Made you worse? Comments
Trimipramine (Surmontil)	❑	❑	❑	
Atypical Antidepressants				
Bupropion (Wellbutrin)	❑	❑	❑	
Mirtazapine (Remeron)	❑	❑	❑	
Nefazodone (Serzone)	❑	❑	❑	
Trazodone (Desyrel)	❑	❑	❑	
Monoamine Oxidase Inhibitors				
Isocarboxacid (Marplan)	❑	❑	❑	
Phenelzine (Nardil)	❑	❑	❑	
Selegiline (Emsam, Eldypryl)	❑	❑	❑	
Tranylcipromine (Parnate)	❑	❑	❑	
Other Antidepressants or Add-On Drugs				
L-Methylfolate (Deplin)	❑	❑	❑	
Ketamine/Esketamine	❑	❑	❑	
Pramipexole (Mirapex)	❑	❑	❑	
Omega-3 Fatty Acids	❑	❑	❑	
SAMe	❑	❑	❑	
St. John's Wort	❑	❑	❑	
Thyroid Medicine	❑	❑	❑	
Testosterone	❑	❑	❑	
Vitamin D	❑	❑	❑	
<u>MOOD STABILIZERS:</u>				
Carbamazepine (Tegretol)	❑	❑	❑	
Divalproex (Depakote)	❑	❑	❑	
Lamotrigine (Lamictal)	❑	❑	❑	
Lithium	❑	❑	❑	
Oxcarbazepine (Trileptal)	❑	❑	❑	
Other_______________	❑	❑	❑	
<u>ANTIPSYCHOTIC/MOOD STABILIZING MEDICATIONS:</u>				
Antipsychotic/Mood Stabilizers				
Aripriprazole (Abilify)	❑	❑	❑	
Asenapine (Saphris)	❑	❑	❑	
Cariprazine (Vraylar)	❑	❑	❑	
Clozapine (Clozaril)	❑	❑	❑	
Fluphenazine (Prolixin)	❑	❑	❑	
Haloperidol (Haldol)	❑	❑	❑	
Iloperidone (Fanapt)	❑	❑	❑	
Lurasidone (Latuda)	❑	❑	❑	
Olanzapine (Zyprexa)	❑	❑	❑	
Paliperidone (Invega)	❑	❑	❑	
Perphenazine (Trilafon)	❑	❑	❑	
Quetiapine (Seroquel)	❑	❑	❑	
Risperidone (Risperdal)	❑	❑	❑	

Ziprasidone (Geodon)	❑	❑	❑	________________________________
Other______________	❑	❑	❑	________________________________

ANTI-ANXIETY MEDICATIONS:

Benzodiazepines	**Tried?**	**Taken for at Least 6 weeks?**	**Drug added to another Or to boost effect?**	**Helped? Made you worse? Comments**
Alprazolam (Xanax)	❑	❑	❑	________________________________
Chlordiazepoxide (Librium)	❑	❑	❑	________________________________
Clonazepam (Klonopin)	❑	❑	❑	________________________________
Diazepam (Valium)	❑	❑	❑	________________________________
Lorazepam (Ativan)	❑	❑	❑	________________________________
Oxazepam (Serax)	❑	❑	❑	________________________________
Other______________	❑	❑	❑	________________________________

Other Anti-Anxiety Medications

Buspirone (Buspar)	❑	❑	❑	________________________________
Hydroxyzine (Atarax)	❑	❑	❑	________________________________
Gabapentin (Neurontin)	❑	❑	❑	________________________________
Propranolol (Inderal)	❑	❑	❑	________________________________
Other______________	❑	❑	❑	________________________________

STIMULANT/ADHD MEDICATIONS:

	Tried?	**Taken for at Least 6 weeks?**	**Drug added to another Or to boost effect?**	**Helped? Made you worse? Comments**
Amphetamine (Dexedrine)	❑	❑	❑	________________________________
Atomoxetine (Straterra)	❑	❑	❑	________________________________
Clonidine (Catapres)	❑	❑	❑	________________________________
Dextro-amphetamine-amphetamine (Adderall)	❑	❑	❑	________________________________
Dexylmethylphenidate (Focalin)	❑	❑	❑	________________________________
Guanfacine (Intuniv, Tenex)	❑	❑	❑	________________________________
Lisdexamfetamine (Vyvanse)	❑	❑	❑	________________________________
Methylphenidate (Ritalin, Concerta)	❑	❑	❑	________________________________
Modafinil/Armodafinil (Provigil, Nuvigil)	❑	❑	❑	________________________________
Other______________	❑	❑	❑	________________________________

SLEEPING MEDICATIONS:

Eszopiclone (Lunesta)	❑	❑	❑	________________________________
Melatonin	❑	❑	❑	________________________________
Ramelteon (Rozerem)	❑	❑	❑	________________________________
Melatonin	❑	❑	❑	________________________________
Suvorexant (Belsomra)	❑	❑	❑	________________________________
Temazepam (Restoril)	❑	❑	❑	________________________________
Zaleplon (Sonata)	❑	❑	❑	________________________________
Zolpidem (Ambien)	❑	❑	❑	________________________________
Other______________	❑	❑	❑	________________________________

OTHER PSYCHIATRIC TREATMENTS:

	Tried?	Tried for at Least 6 weeks?	No. of Treatments	Helped? Made you worse? Comments
Deep Brain Stimulation	❑	❑	__________	___________________________________
Electroconvulsive Therapy (ECT)	❑	❑	__________	___________________________________
Transcranial Magnetic Stimulation (TMS)	❑	❑	__________	___________________________________

Substance Use History

In the last year, have you ever drunk or used drugs more than you meant to? ❑Yes ❑No

Have you felt you wanted or needed to cut down on your drinking or drug use in the last year? ❑Yes ❑No

In your opinion, what was the impact of your substance use on your work, school, relationships or health?

❑ No impact ❑ Some mild impact ❑ Moderate impact ❑ Severe impact

What substances are you using now or in the past?

❑ **Caffeine**	❑ Currently	❑ Past Use	❑ Frequency_______________	❑ Problem?
❑ **Tobacco**	❑ Currently	❑ Past Use	❑ Frequency_______________	❑ Problem?
❑ **Vape/Juul**	❑ Currently	❑ Past Use	❑ Frequency_______________	❑ Problem?
❑ **Alcohol**	❑ Currently	❑ Past Use	❑ Frequency_______________	❑ Problem?
❑ **Marijuana/CBD**	❑ Currently	❑ Past Use	❑ Frequency_______________	❑ Problem?
❑ **Amphetamine**	❑ Currently	❑ Past Use	❑ Frequency_______________	❑ Problem?
❑ **Cocaine**	❑ Currently	❑ Past Use	❑ Frequency_______________	❑ Problem?
❑ **Hallucinogens**	❑ Currently	❑ Past Use	❑ Frequency_______________	❑ Problem?
❑ **Opiates**	❑ Currently	❑ Past Use	❑ Frequency_______________	❑ Problem?
❑ **Sedatives/Tranquilizers**	❑ Currently	❑ Past Use	❑ Frequency_______________	❑ Problem?
❑ **Inhalants**	❑ Currently	❑ Past Use	❑ Frequency_______________	❑ Problem?
❑ **Over-the Counter Drugs**	❑ Currently	❑ Past Use	❑ Frequency_______________	❑ Problem?
❑ **Other**_________________	❑ Currently	❑ Past Use	❑ Frequency_______________	❑ Problem?

PATIENT HEALTH QUESTIONNAIRE – 8 (PHQ-8)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3

__0__ + _____ + _____ + _____

= Total _______

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

Anxiety (GAD-7)

Please circle the one response to each item that best describes you over the past 2 weeks:

Over the last 2 (two) weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Total _____ =	_____ +	_____ +	_____ +	_____