TRI COUNTY BEHAVIORAL HEALTH

9263 Medical Plaza Dr, Ste. A
North Charleston, SC 29406

843-377-1600 (phone)
843-377-1600 (fax)

Dear patient:

Thank you for choosing Tricounty Behavioral Health to be your TMS therapy provider. We look forward to working with you. **Most insurance networks require a prior authorization** before you begin TMS. We will communicate with your insurance company to obtain prior authorization for TMS services.

We've designed our TMS Intake Form based on the information that will be required by insurance for prior authorization. So, while we understand no one enjoys filling out these types of forms, **we ask that you please be as thorough as possible.** If you can't remember specific dates, especially regarding previous medications, then just list an approximate date, including month and year.

Most insurance will require the following:

- Diagnosis of depression (moderate to severe)
- Minimum of 3-4 antidepressant trials
- History of psychotherapy (therapists, counselor, group therapy, outpatient therapy, extended visits with psychiatrist, or psychologists)
- PHQ-9 (Depression screening) score of at least 18

Thank you for taking the time to complete our intake forms and we look forward to helping you to long-term relief from your depression.

The Tricounty Behavioral Health team

TRANSCRANIAL MAGNETIC STIMULATION INTAKE FORM

NAME_____Date of Birth:_____

Name of person who referred you for TMS: _____
Please circle: Psychiatrist/Therapist/Primary Care Provider/Other
Referral phone number: _____May we contact him/her? YES / NO

Do you have a diagnosis of Major Depression: YES / NO
At what age were you first diagnosed with depression:_____
Have you ever been in remission from depression: YES / NO If so, when? _____

CURRENT PSYCHIATRIC MEDICATIONS:

Medication	Dose	Start Date

PREVIOUS PSYCHIATRIC MEDICATIONS. *If you are unsure of dates list approximate month/year.* See list of common medications below. **Attach additional** sheets of **paper** if necessary.

Medication	Dose	Start Date (mo/yr)	S top Date (mo/yr)	Reason for Discontinuation

Prozac/fluoxetine, Lexapro/escitalopram, Zoloft/sertraline, Celexa/citalopram, Paxil/paroxetine, Luvox/fluvoxamine), Effexor/venlafaxine, Pristiq/desvenlafaxine, Cymbalta/duloxetine, Fetzima, Wellbutrin/bupropion, Viibryd, Trintellix, Spravato (esketamine), Elavil/amitriptyline, Abilify/aripiprazole, Haldol, Risperdal/risperidone, Invega/paliperidone, Saphris/asenapine, Zyprexa/olanzapine, Seroquel/quetiapine, Geodon/ziprasidone, Latuda, Rexulti, Vraylar, Fanapt, Xanax/alprazolam, Ativan/lorazepam, Klonopin/clonazepam, Valium/diazepam, Provigil, Nuvigil, Topamax/topiramate, Remeron/mirtazapine, Neurontin/gabapentin, Lyrica, lithium, Lamictal/lamotrigine, Depakote/valproate/divalproex, Tegretol/carbamazepine, Trileptal/oxcarbazepine, Ritalin, Focalin, Concerta, Adderall, Vyvanse, Ambien, Lunesta, Sonata, Restoril/temazepam, Trazodone, Halcion, Trazodone

Are you currently taking or have you ever taken any medication for seizures: YES / NO
If so, what medication: _____ Start Date:_____Stop Date: _____
In the past 6 months, have you used alcohol, illicit drugs, or taken benzodiazepines (Klonopin, Xanax, Ativan, Valium…): YES / NO
If you drink alcohol, how much/how often: _____
If you use illicit drugs, which ones: Marijuana / Opiates / Cocaine / Hallucinogens / Other_____
If you use benzodiazepines, which one(s):_____How many mg per day: _____

Have you ever been diagnosed with:

Bipolar	YES / NO	Seizures/Epilepsy	YES / NO
Pseudoseizure	YES / NO	Autism	YES / NO
Schizophrenia	YES / NO	Substance Use Disorder	YES / NO
PTSD	YES / NO	OCD	YES / NO

Eating Disorder YES / NO Dementia/Alzheimer's YES / NO
Stroke YES / NO

Please circle the following symptoms you experienced when your depression *first started:*

Loss of hope	Low self-esteem	Insomnia	Sleeping too much
Appetite change	Sadness/feeling down	Loss of interest	Decreased motivation
Irritability	Decreased social activity	Missed work	

Please circle *current* symptoms you're experiencing:

Loss of hope	Low self-esteem	Insomnia	Sleeping too much
Appetite change	Sadness/feeling down	Loss of interest	Decreased motivation
Irritability	Decreased social activity	Missed work	

Do you have current thoughts of:
Self harm/hurting yourself YES / NO Suicide YES / NO Harming someone else YES / NO

Name of current/prior therapist(s) When (estimate if needed) How long

_____

_____

Please circle the types of psychotherapy have you tried in the past or are you currently in:

Cognitive Behavioral Therapy (CBT)	Client Centered Therapy (CCT/PCT)
Existential Therapy	Psychoanalytic/Psychodynamic Therapy
Dialectical Behavioral Therapy (DBT)	Interpersonal Therapy (IPT)
Mindfulness Therapy	Group Therapy
Extended appointments with psychiatrist	Other:_____

Have you ever been hospitalized for depression? YES / NO
Hospital(s) and Date (s): _____

Have you ever had any of the following in the past:
TMS YES / NO ECT YES / NO Vagus Nerve Stimulator YES / NO
Name of clinic and date:_____
If you've had TMS, which TMS device was used?_____

Do you have any ferromagnetic or other magnetic-sensitive metals implanted in your head or within 30 cm of your head, such as a cochlear implant? YES / NO

Are you currently pregnant? YES / NO Are you currently breastfeeding? YES / NO

I attest that I that I have completed the above assessment and the information provided is true and accurate to the best of my knowledge. I authorize Tricounty Behavioral Health to submit a pre-authorization request to my insurance and my requested medical records if necessary.

_____
Patient Signature Date

_____
Printed Name