Transcranial Magnetic Stimulation (TMS) - Concurrent Request

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TMS Coordinator Information

TMS Coordinator Name:* TMS Coordinator Contact #:* ___-___-____ TMS Coordinator E-mail:*

Is this a telephonic request? (INTERNAL OPTUM USE ONLY)**
○ Yes ◉ No

Psychiatrist & Provider Contact Information

Ordering Psychiatrist Name:* Ordering Psychiatrist Contact #:* ___-___-____ Tax ID # for TMS Services:* Servicing Address:

Treatment Information

Does participant continue to meet initial criteria for TMS treatment?**
○ Yes ○ No

Would an alternative treatment be more appropriate to address the members ongoing symptoms?**
○ Yes ○ No

Participant is in agreement to continue TMS treatment?**
○ Yes ○ No

Has the participant been adherent with their treatment plan?**
○ Yes ○ No

Treatment is still necessary to reduce symptoms and improve functioning?**
○ Yes ○ No

Has there been progress towards treatment goals?**
○ Yes ○ No

Describe objective progress in relation to specific symptoms:*

Has treatment plan been modified?**
○ Yes ○ No

Has coordination with family and/or community supports occurred?**
○ Yes ○ No

Has a medication assessment been completed?**

◯ Yes ◯ No

Any medications trials initiated or ruled out?**

◯ Yes ◯ No

I hereby attest that all of the information above is true and accurate to the best of my knowledge*

☐

Submitter's Name:* ________ Submitter's E-Mail:* ________

Data Capture Required:

◉ Yes