Michigan Advanced Psychiatry

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Referral Form

Patient Name_____

Patient Email_____

Patient Phone Number_____

Patient Date of Birth_____

Diagnosis

- ☐ F32.2 Major Depressive Disorder, Single Episode
- ☐ F33.2 Major Depressive Disorder, Recurrent
- ☐ F42.9 Obsessive-Compulsive Disorder, Unspecified

Does the patient have any metallic implants above the neckline?

- ☐ Yes
- ☐ No

Does this patient have a history of seizures?

- ☐ Yes
- ☐ No

Does this person have a history of cerebral arteriovenous malformations or aneurysms?

- ☐ Yes
- ☐ No

Referring Provider Name_____

Referring Provider Email_____

Referring Provider Phone Number_____

This is a referral for:

- ☐ Transcranial Magnetic Stimulation/Deep TMS
- ☐ Spravato treatment
- ☐ Medication Evaluation/Management

Additional Notes:

Signature____ Date_____________________________