SAN ANTONIO BEHAVIORAL HEALTHCARE HOSPITAL

Transcranial Magnetic Stimulation (TMS) Referral Packet

SAN ANTONIO BEHAVIORAL HEALTHCARE HOSPITAL

TMS: Referral Form

Patient's Demographic Information			
Name		Date of Birth	
Address		Phone Number	

Referring Physician Information			
Physician Name		If applicable, Medical Practice Name	
Physician or Medical Practice Address		Physician or Medical Practice Phone Number	
Patient Diagnosis (ICD10)			
Reason for Referral:			

Physician Signature: _____ Date: _____

Patient Signature: _____ Date: _____

Email this referral form to tms@sanantoniobehavioral.com or fax to 210-541-5279. Any questions please call us at 210-541-5289.

SAN ANTONIO BEHAVIORAL HEALTHCARE HOSPITAL

Medical Pre-Screening Questionnaire

Have you ever had a seizure	☐ Yes	☐ No
Have you ever had a Traumatic Brain Injury (TBI)	☐ Yes	☐ No
Have you ever had TMS before	☐ Yes	☐ No
Do you have a diagnosis of: Depression, Major Depressive Disorder, or Bipolar II Disorder	☐ Yes	☐ No
Do you have tattoos in the head and/or neck area	☐ Yes	☐ No
Do you have any metal implants in the head and/or neck area	☐ Yes	☐ No
Do you have an active alcohol use disorder	☐ Yes	☐ No
In your lifetime, have you been prescribed 4 different antidepressant medications	☐ Yes	☐ No

Please circle all medications that apply, highest dosage tried, and year in which you tried them:

desvenlafaxine (Pristiq) • Year: • Highest dosage:	fluoxetine (Prozac) • Year: • Highest dosage:
duloxetine (Cymbalta) • Year: • Highest dosage:	fluvoxamine (Luvox) • Year: • Highest dosage:
venlafaxine (Effexor) • Year: • Highest dosage:	fluvoxamine CR (Luvox CR) • Year: • Highest dosage:
venlafaxine XR (Effexor XR) • Year: • Highest dosage:	paroxetine (Paxil) • Year: • Highest dosage:
milnacipran (Savella) • Year: • Highest dosage:	paroxetine CR (Paxil CR) • Year: • Highest dosage:
levomilnacipran (Fetzima) • Year: • Highest dosage:	sertraline (Zoloft) • Year: • Highest dosage:
citalopram (Celexa) • Year: • Highest dosage:	bupropion (Wellbutrin) • Year: • Highest dosage:
escitalopram (Lexapro) • Year: • Highest dosage:	mirtazapine (Remeron) • Year: • Highest dosage:
nefazodone (Serzone) • Year: • Highest dosage:	trazodone (Desyrel) • Year • Highest dosage:

vilazodone (Viibryd) • Year: • Highest dosage:	vortioxetine (Brintellix) • Year: • Highest dosage:
amitriptyline (Elavil) • Year: • Highest dosage:	desipramine (Norpramin) • Year: • Highest dosage:
doxepine (Sinequan) • Year: • Highest dosage:	imipramine (Tofranil) • Year: • Highest dosage:
nortriptyline (Pamelor) • Year: • Highest dosage:	amoxapine (Anafranil) • Year: • Highest dosage:
maprotiline (Ludiomil) • Year: • Highest dosage:	trimipramine (Surmontil) • Year: • Highest dosage:
protriptyline (Vivactil) • Year: • Highest dosage:	isocarboxazid (Marplan) • Year: • Highest dosage:
selegiline (Emsam) • Year: • Highest dosage:	aripiprazole (Abilify) • Year: • Highest dosage:
quetiapine (Seroquel) • Year: • Highest dosage:	tranylcypromine sulfate (Parnate) • Year: • Highest dosage:

Why didn't these medications work?

Do you currently have a psychiatrist	☐ Yes	☐ No
Do you currently have a therapist	☐ Yes	☐ No

Have you ever been in a psychiatric hospital, circle all that apply:
• Inpatient
  ○ Date:
• PHP
  ○ Date:
• IOP
  ○ Date:
	☐ Yes	☐ No

Have you ever had specialized psychotherapy, circle all that apply: • CBT • EMDR • Bio-feedback	☐ Yes	☐ No
Any medical problems or changes we should be aware of, if so, please list:	☐ Yes	☐ No
Please provide information regarding your depressive symptoms. When did your symptoms start, when were you first diagnosed with a depressive disorder, please also add in any other additional information you believe is beneficial to know:		

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	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 figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
		add columns	+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. 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 _____

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PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder

- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder

- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.
Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

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RELEASE OF INFORMATION REQUEST FORM

DISCLOSURE: I, _____, hereby authorize San Antonio Behavioral Healthcare Hospital to release and discuss medical records, (including any information related to medical, surgical, psychological, social, psychiatric, drug and/or alcohol abuse, diagnosis, treatment, prognosis and/or therapy) therein contained. Initial: _____

Please release any information FROM:

_____
(Name)
_____
(Address)
_____
(City) (State) (Zip)

Please release information TO:

San Antonio Behavioral Healthcare Hospital
(Name)
8550 Huebner Road
(Address)
San Antonio TX 78240
(City) (State) (Zip)

The type of access requested is: ☐ Inspection of the Record ☒ Copies of the Record

*** If you wish to pick up medical records, check here: ☐ ☐ Verbal exchange of information related to care only.

*** If you wish to have the medical records mailed to the address above, check here ☐

A charge for copies of medical record sill be assessed, based on Texas copy allowance rule, when the request is for purpose other than care related.

I specifically need the following information released (requests for "any and all records" is NOT acceptable):

_____ Discharge Summary _____ Psychiatric Evaluation _____ History & Physical
_____ Physician Orders _____ Intake Assessment _____ Nursing Assessment
_____ Psychosocial Evaluation _____ Medication Records _____ Other:
_____ Entire Record (reason why): _____

The recipient of the information released may use it only for the following purposes (must be indicated):

__X__ Assessment & Evaluation __X__ Claims Settlement _____ Personal Use
__X__ Continued Care & Treatment _____ Military _____ Aid Entitlement
_____ Placement & Aftercare _____ Health Insurance Enrollment _____ Employer
_____ Legal Proceedings or Advice _____ School/Educational Needs _____ Verbal Exchange
_____ OTHER: _____

The information authorized for release may include information which may be considered information about communicable or venereal diseases, which may include, but are not limited to, diseases such as Hepatitis, Syphilis, Gonorrhea, and the Human Immunodeficiency Virus, also known as Acquired Immune Deficiency Syndrome (AIDS). Initial: _____

I understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol& Drug Abuse records (42 CFR, Part 2), and cannot be disclosed without my written consent unless otherwise provided for in the regulations. This consent is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance on it, and unless further limited by a date stated here _____ _____ will expire after a period of 90 days (3 months). I have a right to receive a copy of this authorization upon my request.

DATE	**TIME**	**PATIENT SIGNATURE (IF SIXTEEN YEARS OR OLDER):**	
RELATIONSHIP	**TIME**	**RESPONSIBLE PARTY SIGNATURE**	
RESPONSIBLE PARTY PHONE NO. **HOME ( ) -**		**WORK ( ) -** **CELL ( ) -**	
DATE	**TIME**	**WITNESS SIGNATURE**	**TITLE**
DATE	**TIME**	**PHYSICIAN SIGNATURE**	

INFORMATION RELEASED FROM THE MEDICAL RECORD:

☐ **Discharge Summary** ☐ **Psychiatric Evaluation** ☐ **History & Physical**
☐ **Medication Records** ☐ **Physician Orders** ☐ **Laboratory Report**
☐ **Intake Assessment** ☐ **Nursing Assessment** ☐ **Entire Record**
☐ **Other:** _____

Records copied by: _____ Date sent: _____

Via: ☐ U.S. Mail ☐ Pick-up ☐ Other _____

Records given to: _____

Faxed to phone number: (_____) _____ Attention: _____

Thank you for choosing San Antonio Behavioral Healthcare Hospital. One of our staff will meet with you to complete an assessment, and discuss your needs and available resources. In order to assist you and your family in identifying resources, please complete this form.

Name:	**Sex (Check one):** ☐ Male ☐ Female	**Age:**	**Social Security Number:**
Street Address:	**City**	**State**	**Zip-Code**
Date of Birth:	**Marital Status: (Check one)** ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Partner	**Race: (Check one)** ☐ White ☐ Black ☐ Asian ☐ Amer. Indian ☐ Hispanic ☐ Pac. Islander ☐ Other: _____	
Home Phone:	**Cell Phone:**	**Employer or School:**	
Email Address:		**Preferred Pharmacy Location and Phone Number:**	

Who referred you to San Antonio Behavioral Healthcare Hospital? **Phone:**

Did you have an appointment? Y N **Have you been a patient at this hospital before?** Y N **Did you come in by ambulance or police?** Y N

Emergency Contact:	**Relationship:**	**Phone Number:**

Primary Insurance Company Name	**Policy Number**	**Secondary Insurance Company Name**	**Policy Holder's Date of Birth**
Policy Holder's Name/Relationship	**Policy Holder's Social Security #**	**Policy Holder's Name/Relationship:**	**Policy Holder's Social Security #**
Policy Holder's Employer	**Policy Holder's Date of Birth**	**Policy Holder's Employer:**	**Policy Holder's Date of Birth**

Account Guarantor (For adolescent patients – adult consenting to patient's treatment)

Guarantor's Name/Relationship:	**Guarantor's Date of Birth:**	**Guarantor's Social Security Number:**
Street Address	**City** **State**	**Zip-Code**

Briefly describe the symptoms you are experiencing at this time (why you came in for an assessment):

_____

_____

Primary Care Physician:	**Phone Number:**
Psychiatrist:	**Phone Number:**
Therapist/Counselor:	**Phone Number:**

I hereby grant permission for the following individual(s) to be kept informed of the status of my assessment process:

Name: **Relation:** **Phone#:**

By signing below I authorize staff at San Antonio Behavioral Healthcare Hospital to verify my insurance benefits and to assist with referrals.
By signing below, I acknowledge that I have received the PRIVACY RIGHTS FOR PROTECTED HEALTH INFORMATION.

Patient/Guardian Signature: **Date:**

PATIENT REGISTRATION
San Antonio Behavioral Healthcare Hospital

Patient Label

TMS Medical Screening Questionnaire	
Please read each question carefully, answering accurately and truthfully, and if you have any doubt as to how to answer any question, please mark "yes."	
Do you have epilepsy or have you ever had a convulsion or a seizure?	☐Yes ☐No
Have you ever had a fainting spell? If yes, please describe in which occasion(s)	☐Yes ☐No
Have you ever had severe (i.e. followed by loss of consciousness)head trauma?	☐Yes ☐No
Do you have any hearing problems or ringing in your ears?	☐Yes ☐No
Are you pregnant or is there any chance that you might be?	☐Yes ☐No
Do you have metal in the brain/skull (except titanium)? (E.g. splinters, fragments, clips, etc.)	☐Yes ☐No
Do you have cochlear implants	☐Yes ☐No
Do you have an implanted neurostimulator? (E.g. DBS, epidural /subdural	☐Yes ☐No
Do you have cardiac pacemaker or intracardiac line or metal in your body?	☐Yes ☐No
Do you have a medication infusion device?	☐Yes ☐No
Are you taking any psychiatric or neuroactive medications? (Please list)	☐Yes ☐No
Did you ever undergo TMS in the past? If so, were there any problems?	☐Yes ☐No
Did you ever undergo MRI in the past? If so, were there any problems?	☐Yes ☐No
Do you hold a Heavy Goods Vehicle driving license, pilot's license or bus license?	☐Yes ☐No
Do you have any existing medical condition or undertaking treatment for an existing medical condition?	☐Yes ☐No
Do you have tattoos in the head or neck areas?	☐Yes ☐No

I confirm that I have read and understood the above questions and that each question has been answered to the best of my knowledge.

Patient name: _____ Signature: _____

Date: _____ Time: _____

Staff name: _____ Signature: _____

Date: _____ Time: _____

DISCLOSURE AND CONSENT TO ASSESSMENT

San Antonio Behavioral Healthcare Hospital lawfully and ethically operates an assessment service at no cost. The service provides assessments by licensed mental health clinicians at the hospital or at a neutral location. The clinician may refer appropriate patients for outpatient treatment or to a physician for further evaluation and possible admission to the facility.

Before referring and / or assessing a person, San Antonio Behavioral Healthcare Hospital must disclose the following to each individual seeking assessment or treatment:

1. San Antonio Behavioral Healthcare Hospital does not discriminate on the basis of race, color, national origin, disability, sexual orientation, or age.

2. San Antonio Behavioral Healthcare Hospital is not obligated to provide an assessment by a physician unless deemed necessary by the assessment clinician. Physician assessments are billable services.

3. The assessment is voluntary and the client is free to choose whether they want to pursue further treatment. However, if the licensed clinician conducting the assessment deems the individual to be a potential danger to self or others, gravely impaired/psychotic, and may meet criteria for involuntary treatment, an Emergency Detention may be sought as stipulated in Chapter 573 of the Texas Health and Safety Code. The individual will be screened by a physician prior to admission.

4. The assessment clinician is an employee of San Antonio Behavioral Healthcare Hospital.

5. The assessment is confidential unless the client gives permission in writing to release information.

6. Specific mental health professionals the client may be referred to are licensed and meet clinical and ethical standards of San Antonio Behavioral Healthcare Hospital.

7. Financial reimbursements are never given or received by San Antonio Behavioral Healthcare Hospital based on referrals.

I certify that I have read and understand the above consent for assessment. I agree to absolve San Antonio Behavioral Healthcare Hospital and its staff rendering the treatment(s) from any liability.

_____
Print Patient Name

_____ _____
I CONSENT to assessment (Patient/ Guardian Signature) Date/ Time

_____ _____
I REFUSE assessment (Patient/ Guardian Signature) Date/ Time

_____ _____
Staff Signature Date/Time