



**Transcranial Magnetic Stimulation (TMS)**  
Pretreatment Certification Form

**Patient Information**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_ Sex: M F

Insurance ID#: \_\_\_\_\_ Insurance Plan/Employer: \_\_\_\_\_

Diagnosis (ICD-10): \_\_\_\_\_

**The following information must be completed and submitted along with your evaluation for review. Documentation must be completed within a three-month period from the requested start date of treatment.**

Name/Contact information of treatment team:

- Psychiatrist Name: \_\_\_\_\_ Phone: \_\_\_\_\_
- Therapist Name: \_\_\_\_\_ Phone: \_\_\_\_\_
- Other (Name/Specialty): \_\_\_\_\_ Phone: \_\_\_\_\_

Confirmed diagnosis of severe depression (either single or recurrent episode):  Yes  No

Description of response to prior treatment: \_\_\_\_\_

Two (2) or more trials of psychopharmacological agents in the current or previous episode without adequate response. Treatment trials included antidepressant medication at or above the minimum effective dose and duration:

Treatment trials have included at least one (1) evidence-based medication augmentation therapy with mood stabilizers:  Yes  No

Evidence that the patient is unable to tolerate psychopharmacological agents due to serious side effects:

Does the patient have a history of good response to TMS treatment in a previous depressive episode?

Yes  No (If no, explain: \_\_\_\_\_)

At least two different depression scales administered throughout treatment to monitor clinical response (ie. Beck Depression Inventory, Hamilton Depression Rating Scale, Montgomery-Asberg Depression Scale, Personal Health Questionnaire Depression Scale, or the Quick Inventory of Persistent Symptomatology).

**Include copies of completed scales with this document when treatment is requested.**



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Has the patient received electro-convulsive therapy in the past and/or is TMS being considered as a less-invasive treatment option?  Yes  No

Has the patient received a trial evidenced-based psychotherapy in the treatment of Major Depressive Disorder?  Yes  No If Yes, did the psychotherapy result in any significant improvement?  Yes  No

Will TMS be administered by an FDA-approved TMS device in the treatment of major depression, following recommendations of the manufacturer's use or manual in a safe and effective manner?  Yes  No - Please specify which device will be utilized: \_\_\_\_\_

Will the treatment course follow specific stimulation parameters? (e.g. five (5) days per week for six (6) weeks, total of 30 sessions, followed by a three-week taper of three (3) treatment sessions for one week, two (2) treatment sessions the next week and one (1) treatment session the following week).  Yes  No

Specify: \_\_\_\_\_  
 \_\_\_\_\_

Does the patient have a history of seizure disorder, or is the patient currently having uncontrolled seizures?  Yes  No

Is the patient displaying any acute psychotic symptoms, or has the patient been diagnosed with schizophrenia, schizophrenic form, or schizoaffective disorder in the current depressive episode?  Yes  No

Does the individual have any neurological condition(s) that includes epilepsy, cerebrovascular disease, increased intracranial pressure, or primary or secondary tumors in the central nervous system?  Yes  No -If yes, list: \_\_\_\_\_

Does the individual have an implanted magnetic sensitive medical device located less than or equal to 30 cm from the TMS magnet coil?  Yes  No  
 If yes, check all that apply:  Cochlear Implant  Implanted Cardiac Defibrillator  Pacemaker  
 VNS stimulator  Metal Aneurysm Clip  Coil, Staples, or Stents  Other Devices

Is this a request for maintenance of TMS treatment?  Yes  No

Is there a recurrence of symptoms after a previous positive response to TMS? \_\_\_\_\_

If so, what was the initial % of symptom reduction and what rating scale was used? \_\_\_\_\_

**Requested Treatment Start Date:** \_\_\_\_\_ *If retro-date requested, reason needed:* \_\_\_\_\_

**My signature below confirms the information provided is accurate and I am providing the requested services**

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Provider Name (Printed): \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_