**Information for Insurance Authorization**

**TMS Treatment Center, PSC**

**(859) 533-9190**

Your Name: Phone #

Date of Birth:

Psychiatrist Name (or doctor who diagnosed you with depression):

Psychiatrist Phone #

I have been diagnosed with moderate or severe depression. Y/N

Therapist Name: Phone #

Do we have your permission to contact these providers? Y/N?

Do you have a diagnosis of severe major depressive disorder (single or recurrent)? Y/N

Date latest episode started:

Other psychiatric diagnoses, if any:

Have you participated in therapy during the current episode? Y/N

Please describe the type of therapy (cognitive-behavioral, interpersonal, etc.)?

How many sessions or weeks/months of therapy?

Did psychotherapy result in significant improvement in your depressive symptoms? Y/N

How many trials of different antidepressants have you had in the current major depressive episode (antidepressant, mood stabilizer, etc.)?

How many in previous episodes (if applicable)?

Have you been treated with TMS in the past (please elaborate)? Y/N

For the current or previous episode of depression, please list the medication trials

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| Medication-Antidepressants | Date of Trial | Maximum Dosage | Duration of Trials | Outcomes, side effects |
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| Medication-Augmentation therapies | Date of Trial | Maximum Dosage | Duration of Trials | Outcomes, side effects |
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Please list specific psychotherapy trials, dates, and outcomes:

What were the ranges of any rating scales of depression (Moderate, Severe or score)?

Other important information you would like us to know: