1220 Main Street, Suite 431, Vancouver, WA 98660
(503) 974-4831 Fax (888) 569-3218

Referral Form

Date: ______________________

Referring Provider: ____

Provider contact info (best, email/phone): ____

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Patient Name: ______________________________ DOB: ____________________

Patient Address: ____

____

Patient Contact phone number/s: ____

Patient has been diagnosed with moderate to severe Major Depressive Disorder that is currently active without psychotic features?

Yes No

Does patient have any implanted metal? Yes No

Examples may include: vagus nerve stimulators, cochlear implants, shunts, pacemakers, defibrillators, aneurysm clips/coils, carotid or cerebral vascular stents, metal fragments/shrapnel, permanent makeup, tattoos – most dental implants are safe

Does patient have a seizure disorder? Yes No

Antidepressant medications tried/failed and approximate dates of use:

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Patient has attended behavioral/psychotherapy? Yes □ No □

Approximate dates/place/therapist?

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Please provide:

- ✓ Front and back copy of all insurance cards (primary/secondary)
- ✓ Recent (within 30 days) PHQ-9