



12574 Flagler Center Blvd. Ste.101
Jacksonville, FL 32258
Phone: 904.827.3714
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Direct Referral for TMS

Please complete this form and submit a current history and physical for the patient. After review of the information by a provider, the patient will be contacted to schedule a formal evaluation visit for TMS.

Patient Personal Information:

Name: _____ Home Phone: _____

DOB: _____ Cell Phone: _____ Work phone: _____

Demographics: Gender: ☐ M ☐ F Age: _____

Behavioral Health:

- | | | | |
|--|---------------------------------------|---|---|
| <input type="radio"/> Daytime Sleepiness | <input type="radio"/> Anxiety | <input type="radio"/> Intrusive Thoughts | <input type="radio"/> Rapid Mood Swings |
| <input type="radio"/> Depression | <input type="radio"/> Racing Thoughts | <input type="radio"/> Poor Sleep | <input type="radio"/> Other |
| <input type="radio"/> Fatigue | | <input type="radio"/> Frequent Awakenings | |
| <input type="radio"/> Home O2 _____ L | | <input type="radio"/> Insomnia | |
| <input type="radio"/> _____ | | | |

Comorbidities:

- | | | | |
|---|--------------------------------------|--------------------------------------|---------------------------------------|
| <input type="radio"/> MI/CAD | <input type="radio"/> TIA/CVA | <input type="radio"/> Pregnant State | <input type="radio"/> Diabetes |
| <input type="radio"/> Neuromuscular Dis | <input type="radio"/> Hypertension | <input type="radio"/> Obesity | <input type="radio"/> Dementia |
| <input type="radio"/> Substance Abuse Cardiac | <input type="radio"/> Hyperlipidemia | | <input type="radio"/> Thyroid Disease |

Consultation Request: _____ Routine _____ Re-Assessment

Special Needs: _____ Oxygen _____ Assistance Moving _____ Wheelchair _____ Difficulty hearing
_____ Communicating
_____ Other: _____

Insurances Accepted: Aetna, FLBC, United Healthcare, Optum, Cigna, Tricare, Medicare

Ordering Physician: _____ Signature: _____ Date: _____