UNIVERSITY OF IOWA HOSPITALS & CLINICS
University of Iowa Health Care

UIHC Interventional Psychiatry Referral form

Electroconvulsive Therapy - (ECT)

Repetitive Transcranial Magnetic Stimulation - (rTMS)

Please fill this form out as completely as possible. Unknown items can be left blank. Please attach recent clinic notes, intake, admission and discharge summaries, and history & physical documentation.

Provider Information ☐ I am the usual provider ☐ I am not the usual mental health provider. Is the usual provider aware of the referral? Y / N

Name/Profession	
Phone	
Fax	
Address	

Patient Information ☐ They have previously been a patient at UIHC ☐ The patient is new to UIHC: Please have them call registration at 1-866-309-0832

Name	
Date of Birth	
Phone (Cell / land)	
Email address	
Address	
Insurance	
Employment status	Will FMLA be needed? Y /N
Current location	☐Home ☐Hospital inpatient ☐Residential facility

Reasons for considering neuromodulation as a treatment modality
Please check all circumstances that apply

Electroconvulsive Therapy	Transcranial Magnetic Stimulation Therapy
☐ Failure of 2 or more medication trials of adequate dose and duration during present episode	☐ Failure of 4 or more medication trials of adequate dose and duration during the current episode of Major Depressive Disorder.
☐ Urgency of presentation – Extreme suicidality, NMS, Catatonia	☐ History of less than optimal response to ECT or poor tolerance of ECT.
☐ History of positive outcome with ECT	☐ History of positive outcome with rTMS
☐ Intolerance of psychotropic medications	☐ Intolerance of psychotropic medications
☐ Patient is considering ECT or rTMS as treatment options, but is seeking more information prior to choosing what course of treatment to pursue.	

Psychiatric Diagnoses – Please list all diagnoses and indicate primary diagnosis.

Past Medication Trials for Psychiatric Conditions – 2 different Classes generally required for rTMS.

Medication	Start (mm/yyyy)	End (mm/yyyy)	Dose	Response, S/Es, Reason for Discontinuation

Psychotherapy – Please provide therapists' names and contact information, many insurance companies require documentation of response to psychotherapy for rTMS coverage.

Name:_____ Phone:_____

Street:_____ Fax:_____

City/State/Zip:_____ Email:_____

Medical Diagnoses – Please include cardiac, respiratory, neurologic conditions, and implanted medical devices.

Current Medications for Psychiatric AND Medical Conditions

Medication	Dose	Start (mm/yyyy) – For Psychiatric Conditions Only

Brain-stim@healthcare.uiowa.edu Fax: (319) 384-5203

Coordinator: Chris Sanborn (319) 384-9162 – christopher-sanborn@uiowa.edu