Referral for TMS, Ketamine and /or ECT

AT BOULDER COMMUNITY HEALTH

PHONE: 303-415-4299 | FAX: 303-441-2202

First opinion referral for TRMD treatments

Referring clinician name:

Clinician contact information:

Patient name: DOB:

Patient contact information:

Mental health diagnosis: (check all that apply)

- ☐ Bipolar disorder
- ☐ Catatonia
- ☐ Major depressive disorder
- ☐ Mania
- ☐ PTSD
- ☐ Schizophrenia / schizoaffective (treatment-resistant type)
- ☐ Treatment-resistant depression
- ☐ Other: (please specify)

History of treatment resistance: (check all that apply)

- ☐ Greater than two failed medication trials
- ☐ ECT fail
- ☐ Ketamine fail
- ☐ TMS fail

Current medications: (include dosages)

BCH offers the following treatments. Indicate which treatment(s) you are submitting a patient referral for:

- ☐ TMS
- ☐ Ketamine infusions
- ☐ ECT

Why is this treatment requested? (Check all that apply.)

- ☐ High acuity
- ☐ Treatment resistance
- ☐ Other: (please specify)

Referring clinician's signature: **Date:**

Please fax pertinent clinical notes and treatment history notes to 303-441-2202