UCLA TMS
Clinical and Research Service

PROVIDER REFERRAL FOR EVALUATION FOR TRANSCRANIAL MAGNETIC STIMULATION TREATMENT

Phone: 310-825-7471 Fax: 310-825-7642

☐ Westwood Campus
760 Westwood Plaza
Suite 58-229
Los Angeles, CA 90024

☐ Pasadena Campus
630 S. Raymond Ave
Suite 336
Pasadena, CA 91105

☐ Calabasas Campus
26585 W Agoura Road
Suite 330
Calabasas, CA 91302

Date: _____

Patient Name: _____

Patient Phone: _____ Patient Date of Birth: _____

Referring Provider: _____ NPI # _____

Provider Email: _____ Provider Phone #: _____

Provider Address: _____

City / State: _____ Zip: _____

EVALUATE AND TREAT FOR:

(Please check one)

- ☐ F32.9 - Major Depressive Disorder, Single Episode
- ☐ F33.2 - Major Depressive Disorder, Recurrent
- ☐ F34.1 - Dysthymic Disorder
- ☐ F42.9 - Obsessive Compulsive Disorder, unspecified
- ☐ H93.19 - Tinnitus, unspecified laterality
- ☐ G89.29 - Chronic Pain, general
- ☐ Other (specify): _____

Additional Notes: _____

Provider Signature: _____

Please fax this form to 310-825-7642, or email to TMSReferrals@mednet.ucla.edu

We also accept internal referrals through CareConnect. Please visit our website at **tms.ucla.edu/schedule.php** for more details.

Thank you for referring your patient to our service.
One of our staff members will contact you promptly.

UCLA Health