CHS BRAIN STIMULATION REFERRAL FORM

NON CHS PROVIDERS

Please indicate patient's location preference for treatment(s) and we will do our best to accommodate:

☐ BH Charlotte/CHS Mercy ☐ BH Davidson/ CHS Huntersville Same Day Surgery

PATIENT INFORMATION

Today's Date:	Full Name:	Date of Birth:
Preferred Phone:		Best time to call:
Patient Insurance Provider:		
Group Number:	ID Number:	

IMPORTANT: To proceed with your referral, we **must** have patient's insurance information as CHS facilities may be out of network. Please include a copy of patient's insurance card (front and back) with referral to fax 704-446-7393. Once we receive your referral and verify insurance benefits, we will contact your patient to schedule a consultation or inform you if we are unable to schedule a consultation for any reason.

REFERRAL INFORMATION

Referring Provider:	Best Contact Number to Reach Referring Provider:
Practice Location:	Fax number:
Brain Stimulation treatment you wish considered for your patient:	☐ ECT only ☐ TMS only ☐ Either, based on evaluation Comment:

PATIENT PSYCHIATRIC DIAGNOSES

CLINICAL SUMMARY/ REASON FOR REFERRAL

Created 10/2016; Rev 11/2017

Carolinas HealthCare System

Patient Identifier

Previous Treatment History

Psychiatric Hospitalizations	When (dates)	Where (facility name, city, state)	Why
Partial Hospitalization Program	When (dates)	Where (facility name, city, state)	Response

Past Brain Stimulation Tx.	When	Where	Treatment Parameters	Response
TMS				
ECT				
Other _____				

Psychotherapy	Provider Name/Location	Duration of treatment	Frequency of visits	Type of therapy	Was frequency or type of therapy adjusted during current episode?	Progress or lack of progress (include any standardized rating scale scores).
Individual						
Group						
Other _____						

Current Psychiatric Medications

Medication	Maximum Dose Reached	Duration	Response /Side effects

Current Non-Psychiatric Medications

Medication	Dose	Frequency

Please attach additional medication sheet if needed

Patient Identifier

Other Psychotropic Medication Trials During CURRENT Episode (i.e., since most recent episode started)			
Medication	Maximum dose reached	Duration	Response /Side effect(s)
Other past Psychotropic medication trials			
Non- Psychiatric Medical History			

Does patient have any metal in his/her body?	☐ YES, where _____ ☐NO	
Non-Psychiatric Medical Diagnoses		
Past Surgeries and Dates		
Primary Care Physician	Phone	Location

Substance Abuse History				
Substance	Amount	Frequency	First use	Last use
Currently in Substance Abuse Treatment? ☐ Yes, or ☐No	If yes, where?			

Referring Physician: ***Must be signed by a Physician, PA, or NP***	
Name (Print):	Signature:
Date:	Time:

Fax Back to 704-446-7393