2366 Eastlake Ave. E., Suite 439
Seattle, WA 98102
P: 206.456.2604
F: 206.492.2020
Contact Us: Info@TMSWashington.com
Visit Us: www.TMSWashington.com

TMS REFERRAL FORM

Date: _____

Patient Info:

Name ☐ Male ☐ Female D.O.B. / /			
(Last Name) *(First Name)* *(Initial)* *(Day)/(Month)/(Year)*			
Address			
(Street)	*(City)*	*(State/Province)*	*(Postal Code)*
Home Phone	Cell Phone	Email	
Insurance Provider:	Policy Number:	Group Number:	

Provider Info:

Referring Provider:		NPI#:	
Provider Address:	City:	State:	Zip:
Provider Phone #:	Provider Fax #:		Provider Email:
Diagnosis:	ICD 10 Codes:		

Please Attach Additional Documentation with Referral Form:

- ☐ Current Medications (Start Dates)
- ☐ Past Medications (Start Date/End Dates, Side Effects or Discontinuation Reason)
- ☐ Patient Chart Notes
- ☐ Copy of Front and Back of Patient Insurance Card

Patient Forms available at www.TMSWashington.com

**** In order for us to best serve the patient, please make sure all boxes are checked, info attached and fax to 206.492.2020**

Comments:

_____

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_____

Provider Signature Date

Thank You for Referring your Patient to TMS Washington