



Pacific Northwest Recovery & Counseling  
TMS Oregon  
Liana Hategan MD PC

## Provider Referral Form

Date: \_\_\_\_\_

Referring Provider: \_\_\_\_\_

Provider contact info (best, email/phone): \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient Address: \_\_\_\_\_

Patient Contact phone number/s: \_\_\_\_\_

Patient has been diagnosed with moderate to severe Major Depressive Disorder that is currently active without psychotic features?

Yes    No

Does patient have any implanted metal? Yes    No    If yes

Examples may include: vagus nerve stimulators, cochlear implants, shunts, pacemakers, defibrillators, aneurysm clips/coils, carotid or cerebral vascular stents, metal fragments/shrapnel, permanent makeup, tattoos. Most dental implants are safe, but please include in response.

Does patient have a seizure disorder? Yes     No

Antidepressant medications tried/failed and approximate dates of use:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient has attended behavioral/psychotherapy? Yes     No

Approximate date(s)/place/therapist?

Please provide:

- ✓ Front and back copy of all insurance cards (primary/secondary)
- ✓ Recent (within 30 days) PHQ-9