TMS Intake Form

Kipuka o ke Ola (KOKO)

(808)885-5900 phone

(808)885-6900 fax

- **Mahalo for your interest in our clinic's TMS services. We are currently working with insurance companies to ensure coverage of patients. In some cases, much documentation is required. We appreciate your kokua and patience!**
- **Most insurance companies require documentation of 2 or more failed antidepressants before they will cover TMS services. Please list these below:**

Patient Name:_____

Patient DOB:_____

1. **Name of Antidepressant:**_____
    a. **Prescriber Name:**_____
    b. **Dates of treatment:**_____
    c. **Maximum dose tolerated:**_____
    d. **Reason for discontinuing medication:**_____
2. **Name of Antidepressant:**_____
    a. **Prescriber Name:**_____
    b. **Dates of treatment:**_____
    c. **Maximum dose tolerated:**_____
    d. **Reason for discontinuing medication:**_____
3. **Name of Antidepressant:**_____
    a. **Prescriber Name:**_____
    b. **Dates of treatment:**_____
    c. **Maximum dose tolerated:**_____
    d. **Reason for discontinuing medication:**_____
4. **Name of Antidepressant:**_____
    a. **Prescriber Name:**_____
    b. **Dates of treatment:**_____
    c. **Maximum dose tolerated:**_____
    d. **Reason for discontinuing medication:**_____