



INTERVENTIONAL PSYCHIATRY REFERRAL FORM

South County Psychiatry (SCP)

RETURN REFERRAL FORM TO:
Email: info@scp-ri.com
OR
Fax: 855-268-5333

Thank you for referring your patient to South County Psychiatry. Our interventional psychiatry services include Transcranial Magnetic Stimulation (TMS) and Esketamine (Spravato). Insurance coverage and eligibility requirements vary by payer. SCP will review the patient's psychiatric, medical, and treatment history to determine clinical appropriateness and assist with authorization requirements.

I AM REFERRING MY PATIENT FOR:

- ☐ TMS Therapy
- ☐ Esketamine (Spravato)
- ☐ Please evaluate my patient and recommend which SCP treatment may be most appropriate

TRANSCRANIAL MAGNETIC STIMULATION (TMS)

Typical clinical considerations: TMS may be considered for patients with Major Depressive Disorder (MDD) and, depending on clinical indication and payer coverage, other FDA-cleared indications. Eligibility and authorization criteria vary by insurance plan.

Important screening considerations: History of seizures or epilepsy, significant brain injury or neurologic disease, and non-removable metal or implanted devices in or near the head should be identified for clinical review.

ESKETAMINE (SPRAVATO)

Typical clinical considerations: Spravato may be considered for eligible patients with Major Depressive Disorder in accordance with current FDA labeling, clinical assessment, and payer requirements.

Important screening considerations: Please identify relevant cardiovascular or cerebrovascular conditions, uncontrolled hypertension, substance-use concerns, pregnancy status, and other medical factors that may affect treatment eligibility.

Please attach the patient's most recent psychiatric/office note and current medication list.

INSTRUCTIONS: Please complete this form and submit it to SCP with the patient's most recent office visit note and current medication list. SCP staff will contact the patient and/or referring office regarding next steps.

REFERRING PROVIDER

Name: _____ Agency: _____
Phone: _____ Fax: _____

CURRENT OUTPATIENT PROVIDER (IF DIFFERENT FROM ABOVE)

Name/Practice: _____

PATIENT INFORMATION

Name: _____ Date of Birth: _____
Phone: _____ Email: _____
Primary Psychiatric Diagnosis: _____ Additional Diagnoses: _____

MEDICATION TREATMENT HISTORY

Please include relevant antidepressant and augmenting medication trials.

Medication	Max Dose	Start Date	End Date	Outcome / Side Effects

TREATMENT HISTORY

Psychotherapy? ☐ Yes ☐ No Name / Dates: _____
TBI or seizures? ☐ Yes ☐ No Describe: _____
Substance Use Disorder? ☐ Yes ☐ No Current Status: _____
Past TMS? ☐ Yes ☐ No When / Outcome: _____
Past Ketamine? ☐ Yes ☐ No When / Outcome: _____
Past Esketamine (Spravato)? ☐ Yes ☐ No When / Outcome: _____

ADDITIONAL NOTES / RELEVANT CLINICAL INFORMATION
