St.JosephHealth
St. Joseph Hospital

Office: (714) 744-8879
Fax: (714) 744-8605

NETS New Patient Information

Patient Name: _____Age:_____ Date of Birth:_____

Home Address: _____ Phone: _____

Instructions: Complete as many sections as you can to assist with a timely review

INSURANCE INFORMATION

Compete the section below If you have not sent in your insurance information.

Member Name: _____ Date of Birth:_____

Home address: _____Contact Number:_____

Insurance Company: _____Member ID#_____

PRACTITIONER INFORMATION (If different or in addition to the physician)

Psychiatrist Name:_____ Phone #: _____

Therapist Name: _____ Phone #:_____

List all diagnoses including current (list Primary Focus of Treatment first):_____

_____

_____

List of Medication Trials for Your Depression

Medications: Antidepressants	Date of Trial	Maximum Dose	Duration of Trial	Outcome, Side-Effects, Other Relevant Info.

Medications: Augmentation Therapies	Date of Trial	Maximum Dose	Duration of Drial	Outcome, Side-Effects, Other Relevant Info.

Psychotherapy Trials and Outcomes

Model of Psychotherapy Used	Focus of Therapy	Rate Range	Frequency/Number of Sessions	Outcome, Side-Effects, Other Relevant Info.

Does the patient have history?

Epilepsy or seizures □ Yes □ No
(except as induced by ECT and associated with febrile seizures in infancy)

Implanted devices sensitive to magnetic fields and within 30 cm of TMS coil □ Yes □ No

Other psychiatric / neuropsychiatric disorders □ Yes □ No

Current substance abuse / dependence □ Yes □ No

Substance abuse? □ Yes □ No
If yes, what substance_____

Fax physician referral to St. Joseph Hospital NETS Center Fax: (714) 744-8605

Physician Name: _____ Phone #: _____

Fax:_____

Physician Address: _____