



# VAGAL NERVE STIMULATOR (VNS) IMPLANTATION REQUEST FORM

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Name: \_\_\_\_\_ Member ID#: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Today's date: \_\_\_\_\_

Implanting surgeon: \_\_\_\_\_ Specialty: \_\_\_\_\_

Post-implant monitoring/adjustment physician: \_\_\_\_\_ Specialty: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ DSM-IV-TR Code: \_\_\_\_\_

Age at first diagnosis: \_\_\_\_\_ Duration of current affective episode: \_\_\_\_\_

List prior medical evaluations conducted to exclude other causes of depressions (i.e. medicine side effects, thyroid disease, substance abuse, etc.): \_\_\_\_\_  
\_\_\_\_\_

**Prior mental health hospitalizations:**

Facility Name	Year	Duration

**Antidepressant medication trials:**

Name	Year	Duration	Result	ADR

**Augmentation medication trials (lithium, thyroid, "atypical anti-psychotics," etc.):**

Name	Year	Duration	Result	ADR

**ECT treatment:**

MD	Facility	Date	Number in series	Results

Document maintenance ECT and results:

Current Hamilton Depression Rating Scale score: \_\_\_\_\_ Date: \_\_\_\_\_

Other mood rating scale name: \_\_\_\_\_ Score: \_\_\_\_\_ Date: \_\_\_\_\_

Document current levels of impairment (unable to work, receiving disability, etc):

Contact with the patient's primary care physician is strongly recommended.

Date of contact: \_\_\_\_\_ Method of contact:  Telephone  Fax  Progress Note

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Physician Signature

Date

Please fax completed form, along with copies of pertinent medical records,  
to BlueChoice® HealthPlan Health Care Services at 1-800-610-5685.

Thank you.