Medical Verification Form

Patient below is required to confirm their MDD diagnosis to participate in the study entitled: "*Real-World Comparison of Antidepressant Treatments in Patients with Major Depressive Disorder (MDD)".* This study aims to gain a better understanding of patient's medication and treatment experience, including how the therapies manage their symptoms, what the side effects may be, the impact of switching medications, and to track any treatment goals they may have. This study is being conducted by PatientsLikeMe, in partnership with Takeda. The health data that you share in this study will be used only for research purposes. For any additional information please contact the PI at researchstudy001@patientslikeme.com or at 857-663-7576.

PATIENT INFORMATION

Patient First Name: _____ MI: _____ Patient Last Name: _____

Date of Birth: _____ / _____ / _____

THIS SECTION TO BE COMPLETED ONLY BY A LICENSED PROFESSIONAL

HEALTHCARE PROVIDER INFORMATION

First Name: _____ Last Name: _____

Title: _____

Name of Practice: _____ License No.: _____

Street Address: _____ City: _____ ZIP Code: _____

Diagnostic Statement:

_____

_____

_____

ICD-10 Code: _____

Description of the diagnosis:

_____

_____

_____

Date of diagnosis(es): _____

Current antidepressant medication (Medication name and dosage regimen):

_____

_____

_____

I certify that the information contained in this application is true and correct to the best of my knowledge and ability. I hereby verify that the diagnosis listed above has been reviewed by me, is accurate and true, and represents the current physical and/or mental condition of the applicant named on this form.

Signature: _____

Date: _____ / _____ / _____