Transcranial Magnetic Stimulation Referral Form

Referrer Information: ☐ **GP** ☐ **Psychiatrist**

Name:

Address:

Phone:

Email:

Patient Information:

Name: DOB: / / NHI:

Age: Gender:

Address:

Email Address:

Mobile: Home: Work:

Psychiatric History: Please include history of depression, number of episodes, anti-depressant medications trialled.

Current Medications & Doses.

☐ **Please attach any psychiatrist letters/discharge summaries**

Yes / No - Has the patient had TMS in the past? If yes, please provide brief details:

Past Medical History: Possible contraindications of TMS:

Epilepsy	Yes/No	Implants	Yes/No	Head Injury	Yes/No
Seizures	Yes/No	Neurosurgery	Yes/No	Tinnitus	Yes/No
Neurological Illness	Yes/No	Cochlear implants	Yes/No	Medication pump	Yes/No
Metal Plates	Yes/No	Pacemaker/ICD	Yes/No	Concussion	Yes/No

If yes to any, please give details: (attach additional pages if required)

Allergies to medications: Y / N (please specify if yes)

How did you hear about us?

Patient ☐ Web Search ☐

Conference ☐ Colleague ☐

Word of mouth ☐ CME presentation ☐

Other (please specify) ☐

Please ensure any psychiatrists letters/discharge summaries or other relevant information in attached.

Signature:---------- **Date:----------**