QueenslandTMS

Novel Treatment Program Referral Form

Please ensure all categories are completed prior to submission.

This referral form is for assessment and if patient is suitable, the administration of Novel Treatment at QueenslandTMS.

Patient Name: _____

Address: _____

DOB: _____ **Phone:** _____

Medicare No: _____ **DVA/Workcover No:** _____

Medical Diagnosis:

Alcohol or drug misuse	☐ Yes ☐ No	Head injury/neurological disorder	☐ Yes ☐ No
Concussion	☐ Yes ☐ No	Hepatic disease	☐ Yes ☐ No
Cardiovascular condition	☐ Yes ☐ No	Hypertension	☐ Yes ☐ No
Chronic pain	☐ Yes ☐ No	Kidney problems	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	Past Ketamine use	☐ Yes ☐ No
Hallucinations/dissociation	☐ Yes ☐ No	Urinary or bladder condition	☐ Yes ☐ No

Referring doctor: _____ **Provider No:** _____

Practice name/address: _____

_____

Phone: _____ **Signature:** _____ **Date:** _____

Referring Doctor Declaration:

☐ I am referring this patient as their usual treating Psychiatrist or GP who will be providing their ongoing management and care.

QueenslandTMS Novel Treatment program is medically supervised, but all patients must have their own Psychiatrist or GP who continues to provide primary care during the course of novel treatment.

P +61 7 4019 7791 **F** +61 7 4019 7792 **E** admin@qldtms.com **qldtms.com**