QueenslandTMS

Transcranial Magnetic Stimulation Referral Form

Patient Name: _____

Address: _____

DOB: _____ **Phone:** _____

Medicare No: _____ **Health Fund Member No:** _____

Diagnosis/Reason for referral: _____

_____

_____

	YES	NO
Previous trial of TMS	☐	☐
Trial of two or more antidepressants with insufficient response or unacceptable side effects	☐	☐
History of epilepsy/seizures	☐	☐
History of head injury/neurosurgery	☐	☐
Metal or implanted devices in head or neck area	☐	☐
Pregnancy	☐	☐
Pacemaker	☐	☐

Additional information: _____

_____

_____

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

Practice name/address: _____

_____

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

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