

Referral Form: rTMS Treatment

To: TMS Psychiatrist

Patient Details

Name:

DOB: .../.../... Mobile: Home:

Address :

Email Address :Health Fund:

☐ Defence ☐ DVA ☐ Workcover ☐ Health Insurance ☐ Private ☐ Other

☐ Referral for rTMS Consultation and/or Management as appropriate

Clinical Details

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Diagnosis:

☐ Major Depressive Disorder

☐ Bipolar Disorder

☐ PTSD

☐ Other:

Previous TMS Treatment : ☐ Yes

☐ No

☐ Booster Referral

Details :

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Contradictions:

☐ Epilepsy/Seizure History

☐ Neurosurgical Implant/Pump

☐ Pacemaker/Cochlear Implant

☐ Pregnancy

☐ Recent CVS event (Stroke/Aneurysm) ☐ Neurological Disorder

☐ Metal fragment in eye (welding/accident)

Referring Doctor

Name:

Provider Number:

Signature:

Date: / /

Please email to: **admin@yerongacclinic.com.au** OR fax to **Yeronga Clinic** on **(07)3892 5679**