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Direct Referral For Transcranial Magnetic Stimulation (TMS)

PATIENT DETAILS

Surname

First Name DOB / /

Address

Postcode

Telephone (H) (B) (M)

INDICATION FOR TMS

Specialist Consultation/Treatment if indicated

☐ Depression ☐ OCD ☐ PTSD ☐ Pain Management ☐ Other Indications

Clinical Details:

ADDITIONAL INFORMATION

POTENTIAL RISKS

☐ Epilepsy/history of seizures
☐ Eye injuries
☐ Pacemaker or any other implantable medical devices
☐ Neurosurgery
☐ Cochlear implant
☐ Previous problems with TMS

ALLERGIES/OTHER RISKS

☐ No ☐ Yes Specify:

REFERRING PRACTITIONER

Name Provider No.

Practice Address

Contact No. Email

Doctor's Signature Date / /

REFERRER'S PLEASE NOTE: You can assist us by requesting the following MRI:*"MRI to rule out of any neurological causes of the presenting complaints (state the reason for TMS referral). Technically required for TMS planning for neuronavigation. T1 weighted MRI to cover nose, ears and posterior head. Slice distance 1mm. In-plane resolution 1x1mm^2. Please identify left hand knob & left DLPFC".* Thank you.

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