modalis

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:

Main reason for treatment:

☐ Failure of medication ☐ Previous good response to rTMS ☐ Patient preference
☐ Difficult to treat with medications (poor tolerability/risks) Risks: ☐ Suicide ☐ Aggression/agitation

Previous neurostimulation:

☐ rTMS - how many times: ☐ ECT - how many times:

Other concurrent treatment:

☐ Psychopharmacology ☐ Psychotherapy ☐ Individual ☐ Group ☐ Exercise physiology
☐ Coaching and mentoring ☐ Other (please specify):

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:

Additional information:

REFERRING PRACTITIONER

Name Provider No.

Practice Address

Contact No. Email

Doctor's Signature Date / /

REFERRER'S PLEASE NOTE: TMS PROTOCOL - TMS PLANNING FOR NEURONAVIGATION. T1 WEIGHTED MRI TO COVER NOSE, EAR AND POSTERIOR HEAD. SLICE DISTANCE 1MM. IN-PLANE RESOLUTION 1X1MM^2. PLEASE IDENTIFY BILATERAL HAND KNOBS, BILATERAL DLPFC, CZ POINTS AND BILATERAL FACE AREAS.