# Transcranial Magnetic Stimulation Referral

Date of Referral

## Patient Details

Name

Date of Birth

Address

Phone Number

Email address:

Medicare Number:

## Referral Information

Indication for TMS

- [ ] **Depression**
- [ ] **PTSD**
- [ ] **OCD**
- [ ] **Pain**

- [ ] **Other** Please describe in Clinical Details below

Conditions that may affect TMS treatment

- [ ] **Epilepsy or past seizures**
- [ ] **Implantable medical devices**
- [ ] **Eye injuries**
- [ ] **Pacemaker**
- [ ] **Cochlear implant**
- [ ] **Neurosurgery** (eg. Aneurysm clips)

Reason for Referral / Clinical Details

Current Psychiatric Medication

Any current antidepressants, benzodiazepines, mood stabilisers, antipsychotics or anti-seizure medications?

History of Drug and Alcohol Use

Please include current use, amount and frequency

## Referrer

Name

Profession

Practice Name

Practice Address

Email Address

Phone

Provider Number

Signature

**Draw signature** | Type signature Clear

Submit

Save and Complete Later