TMS Clinics AUSTRALIA

Transcranial Magnetic Stimulation Referral Form

Patient Information

Title and Name: .... D.O.B.: ....

Address: ....

Contact Number: .... Email: ....

Medicare Number: .... Ref: .... Valid to: ....

Fund: ☐ DVA ☐ TAC ☐ Workers Compensation ☐ Health Insurance: ....

Membership / claim number: ....

Reason(s) for TMS Referral

☐ Major Depressive Disorder ☐ PTSD ☐ Obsessive Compulsive Disorder

☐ Generalised Anxiety Disorder ☐ Chronic Pain ☐ Tinnitus ☐ Other: ....

Medications and Clinical Notes

In the last 12 months, this patient: ☐ has trialled 2 or more classes of antidepressants (please list below)

☐ has been admitted for psychiatric condition ☐ is currently admitted at: ....

....

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Potential Contraindications (if ticked, please provide additional information)

☐ Epilepsy ☐ Pacemaker ☐ Implantable medical pump or stimulator

☐ Eye or head injury ☐ Neurosurgery ☐ Cochlear Implant

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Referring Doctor

Name: .... Provider Number: ....

Practice Address: ....

Contact Number: .... Email Address: ....

Doctor's Signature: .... Date: ....

Please visit our website for clinic locations

1300 867 888 1300 867 889

info@tmsaustralia.com.au www.tmsaustralia.com.au

Fax referral to our Patient Care Team via
1300 867 889