REFERRAL FORM

PATIENT DETAILS

NAME

ADDRESS

DATE OF BIRTH

PHONE

EMAIL

REASON FOR REFERRAL

MEDICARE ELIGIBILITY

IN THIS EPISODE OF DEPRESSION, HAS THE PATIENT UNSUCCESSFULLY TRIALLED 2 OR MORE CLASSES OF ANTIDEPRESSANT MEDICATIONS FOR AN ADEQUATE PERIOD OF TIME?

☐ YES ☐ NO

HAS THE PATIENT HAD APPROPRIATE PSYCHOLOGICAL TREATMENT FOR THIS EPISODE?

☐ YES ☐ NO

CURRENT MEDICATIONS

MEDICAL CONDITIONS THAT MAY AFFECT TMS TREATMENT (MARK WITH X)

☐	HISTORY OF SEIZURES	☐	METAL PINS OR PLATES IN HEAD
☐	HEAD INJURY	☐	PACEMAKER
☐	NEUROSURGERY	☐	IMPLANTED MEDICAL PUMP OR STIMULATOR
☐	IMPLANT IN HEAD OR NECK	☐	COCHLEAR IMPLANT

REFERRING DOCTOR

NAME

PRACTICE ADDRESS

PHONE

FAX

PROVIDER NUMBER

DATE

EMAIL

DOCTORS SIGNATURE