PATIENT DETAILS

Title/First name _____ Last name _____ DOB _____

Street Address_____Suburb_____ Postcode _____

Preferred method of contact

Complete if your client consents to our Client Care Team contacting them directly to book an appointment.

Mobile_____ Email _____

Name of Emergency contact:_____ Phone Number_____

Funding

The Client Care Team will discuss options with your client and facilitate funding paperwork as required.

Medicare Number _____ Ref: _____Valid until: _____

Fund: ☐ Private / self-funded ☐ Dept. of Veteran Affairs ☐ Workcover ☐ Health fund: _____

Membership / claim number: _____

REFERRAL INFORMATION

Reason(s) for TMS referral

☐ Major depressive disorder ☐ Chronic pain ☐ Generalised anxiety disorder ☐ Smoking addiction

☐ Tinnitus ☐ Obsessive-compulsive disorder ☐ Post-traumatic stress disorder ☐ Other:_____

Medications and clinical notes

Has this client in the past 12 months:

☐ Trialled 2 or more classes of antidepressants and failed to demonstrate an adequate response.

☐ Been admitted for psychiatric condition. If so, please provide additional information below.

Precautions and potential contraindication(s)

(If any are present, please provide additional information below)

☐ Implantable medical pump or stimulator (including pacemaker) ☐ Cochlear implant ☐ Epilepsy

- Additional diagnoses/comorbidities _____
- Current medication _____
- Substance use/abuse/dependence _____
- Risk of harm (if yes, please provide additional information below)_____
- Allergies _____
- Previous treatments – ECT, TMS, hospitalisations, community mental health, therapy _____

_____

Second course of TMS referral:

Did the client demonstrate a satisfactory clinical response to TMS previously (as evidenced by a validated major depressive disorder questionnaire **at least 4 months** after receiving the initial TMS treatment?

☐ Yes ☐ No

Did the client have their previous TMS treatment at our clinic? ☐ Yes ☐ No

REQUESTING DOCTOR

☐ Psychiatrist ☐ GP ☐ Other: _____

Name _____ Provider number _____

Practice Name _____

Practice Address _____

Phone: _____

Email: _____

Doctor Signature: _____

Date: _____

ADDITIONAL INFORMATION

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