ILLAWARRA TMS

Transcranial Magnetic Stimulation for Treatment Resistant Depression

REFERRAL FORM

Referring Doctor

Dr's Name**:**

Practice Name/Address:

Patient

Name:

DOB:

Phone:

Email:

Current antidepressant medication:

Previous antidepressant medications (if known):

Dear IllawarraTMS Psychiatrist,

Please consider if TMS is appropriate for the above patient.

Referring Doctor's Signature:

Provider Number:

Date:

Upload (PDF or Photo) **whilst making your initial consult appointment on HotDoc**
or email: **admin@shellharbourpsychologicalmedicine.com.au**
or Fax: 024295 3644

For more information and to self-book your initial consultation please visit **illawarratms.com.au**

TMS consultations AND all TMS treatment sessions are Bulk-Billed at Illawarra TMS
There is ZERO gap-fee or out of pocket expense to the patient