

Referral for Evaluation of Transcranial Magnetic Stimulation Suitability

PATIENT DETAILS

Full Name:

Address:

DOB:

Preferred method of contact

Complete if your patient consents to our Patient Care Team contacting them directly.

☐ Mobile ☐ Email

Alternative Contact (Optional)

Please provide the details of someone whom our Patient Care Team can contact if we are unable to reach you.

Name Phone Number

Relationship

Health fund

Fund: ☐ Self-funded ☐ Department of Veteran Affairs
☐ Funding ☐ TAC ☐ Worker's Comp
☐ Medicare

Membership / claim number:

Case Manager Contact Number

REFERRING DOCTOR

☐ Psychiatrist ☐ GP ☐ Other:

Name

Optional: doctor / clinic stamp

Provider number

Practice Address

Direct Email
(not reception)

Mobile Number:

Doctor's Signature

Date:

Referral for Evaluation of Transcranial Magnetic Stimulation Suitability

REFERRAL DETAILS

Reason for Referral:

(Please provide a brief summary of the patient's mental health condition)

Previous Treatments:

(Including medications, therapies, and hospitalisations, if applicable)

Can they have an MRI?

☐ Yes ☐ No

Additional Comments/Concerns: