BRISBANE
TMS Group

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# Referral Form Transcranial Magnetic Stimulation

## Patient Details

First Name: _____

Surname: _____

DOB: D D M M Y Y Y Y

Gender: ☐ Male ☐ Female

Contact Ph: _____

Address: _____

_____

_____

Medicare No: _____

Health Fund Member No: _____

## Reason for Referral

_____

_____

_____

_____

## Previous TMS Treatment

Has the patient previously had TMS treatment? ☐ Yes ☐ No _____

_____

Other treating practitioners involved in patient's care: _____

_____

## Medical conditions that may affect TMS treatment

☐ Epilepsy/seizures Head injury: _____

☐ Neurosurgery Implanted devices or pumps: _____

☐ Pacemakers Cochlear Impants: _____

☐ Pregnancy Neurological disorder: _____

If any of the above are ticked (selected) please provide additional information.

## Referring Doctor

Name: _____

Address: _____

Contact Ph: _____ Provider No: _____

Signature: _____ Date: _____

**Please email form to admin@brisbanetmsgroup.com.au**