

Neuronavigated TMS Referral Form

PATIENT INFORMATION	
Name:	Address:
Telephone:	
DOB:	Medicare #:
Email:	Family Physician:
REFERRING PHYSICIAN	
Name:	Please Specify Discipline: <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Family Physician
Address:	Non-physicians are encouraged to contact the CHS Office for more information.
Telephone:	Fax:
PATIENT'S CURRENT PSYCHIATRIST (If applicable)	
Name:	Address:
Telephone:	Fax:
CLINICAL INDICATIONS & MEDICAL HISTORY FOR TMS	
Major Depressive Disorder (History, current/past medications):	Other Relevant History/Comorbidities (e.g Anxiety, OCD, PTSD, Substance Abuse, etc.):

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POTENTIAL CONTRAINDICATIONS FOR TMS

I confirm the patient does not have:

- | | |
|---|--|
| <input type="checkbox"/> Aneurysm Clips or Coils | <input type="checkbox"/> Cochlear/Otologic Implant |
| <input type="checkbox"/> Cardiac Pacemakers, ICDs | <input type="checkbox"/> Implanted Pacemaker |
| <input type="checkbox"/> Cardiac Stents, Filters Valves | <input type="checkbox"/> CSF Shunt |
| <input type="checkbox"/> Carotid or Cerebral stents | <input type="checkbox"/> Ferromagnetic Ocular Implants |
| <input type="checkbox"/> Deep Brain Stimulation Electrodes | <input type="checkbox"/> Magnetically Activated Dental Implants |
| <input type="checkbox"/> Metallic Devices Implanted in Head | <input type="checkbox"/> Non compatible EEG Electrodes |
| <input type="checkbox"/> Facial Tattoos with Metallic Ink | <input type="checkbox"/> Vagus Nerve Stimulator |
| <input type="checkbox"/> Pellets, Bullets, Fragments in Head/Neck | <input type="checkbox"/> Wearable Cardioverter Defibrillator (WCD) |
| <input type="checkbox"/> Metallic Fragments in Eyes | <input type="checkbox"/> Pregnancy |

*The above contraindications pose a safety risk to those undergoing Transcranial Magnetic Stimulation. **Failure to confirm all the above negatives will strictly exclude patients from consideration for TMS treatment.***

Referring Physician Signature:

Date:

FOR INTERNAL USE ONLY

Date received by CHS

Date of Approval:

Approving CHS Psyst (Print):

Approving Psychiatrist's Signature: