TMS Clinics AUSTRALIA

Transcranial Magnetic Stimulation Referral Form

Patient Details

Name:.....

Date of Birth:..... Gender: ☐ Male ☐ Female

Address:.....

Contact Number:..... Email:.....

Medicare Number:.....

Health Fund:..... Membership Number:.....

Clinical Notes

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Details of medication trials conducted in the last 12 months			
Medication/s name:	Date Commenced	Dose (range)	Duration (weeks):

Medical conditions that may affect TMS treatment

☐ Epilepsy ☐ Pacemaker ☐ Implantable medical pumps or stimulators

☐ Eye injuries ☐ Neurosurgery ☐ Cochlear Implants

If any of the above is ticked, please provide additional information

Referring Doctor

Name:.....

Address:.....

Contact Number:..... Provider Number:.....

Doctor's Signature:..... Date:.....

Please visit our website for clinic locations
1300 867 888 1300 867 889
info@tmsaustralia.com.au www.tmsaustralia.com.au

"Please fax referral to **1300 867 889** and our Patient Relationship Manager will liaise with your patient"