Neuralia TMS

Email: referrals@NeuraliaTMS.com.au
Fax: 6230 2231
Website: www.NeuraliaTMS.com.au

Referral Form for Transcranial Magnetic Stimulation

PATIENT DETAILS

Name

Address

DOB

Telephone (H) Telephone (M)

INDICATION FOR TMS

- ☐ Depression
- ☐ PTSD
- ☐ OCD
- ☐ Pain
- ☐ Other

CLINICAL DETAILS

CURRENT AND PAST MEDICATION

ALLERGIES

☐ No ☐ Yes Details:

CONDITIONS THAT MAY AFFECT TMS TREATMENT

- ☐ Epilepsy or Past Seizures
- ☐ Eye injuries
- ☐ Cochlear Implant
- ☐ Implantable medical devices
- ☐ Pacemaker
- ☐ Neurosurgery

REFERRING HEALTH PRACTITIONER

Full name:

Practice:

Address:

Phone: Provider Number:

Doctor's Signature: Date: