FM471 Referral for rTMS Treatment

Referral to TMS Psychiatrist: ☐ via the rTMS service to assist sourcing a TMS Psychiatrist
OR ☐ via the rTMS service to forward onto Doctor ……………………….……..….

Name of Patient: ………………………………………………… **DOB**: ……….…/….…..…./……....……
Contact Numbers Home: ……………………………….**Mobile**: ……………..…………………..............
Email: ……………………………………………………………………………………………………
Health Fund: ………………………………….. **Membership No**: …………………………….……..……
rTMS treatment to be provided as: ☐ **Inpatient** **or** ☐ **Self funded** **or**
☐ **Tailored Therapy (TT) Day Patient** **(5 hour admission)** ***- please complete and attach the TT Referral Form***

Initial rTMS Screening	**Comment / Result**
Does the patient have a history of a major depressive episode? Either unipolar or bipolar affective disorder?	YES / NO………………………………………
Does the patient have persistent symptoms despite trials of at least two antidepressant medications or has the patient been unable to tolerate medication treatment?	YES / NO………………………………………
Does the patient have any of the following contradictions:	
• Epilepsy or another seizure disorder?	YES / NO………………………………………
• A pacemaker?	YES / NO………………………………………
• A cochlear implant or other implanted device?	YES / NO………………………………………
• Metal in the brain or scalp from previous surgery?	YES / NO………………………………………
• Metal in the eye (eg shrapnel)?	YES / NO………………………………………
• Have an active neurological illness?	YES / NO………………………………………

Note: the patient must meet these initial criteria and have none of the contradictions in order for this referral to be progressed and the patient's suitability for rTMS be further assessed.

Diagnosis:……………………………………………………………………………………………………

Current Medications: ……………………………………………………………………………………

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Where possible, please do not change any psychotropic medications one week prior to commencing rTMS or throughout the duration of any rTMS course, without prior consultation with the TMS team.

Pre existing physical problems and / or medical treatment: ……………………………………………

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Additional Information Required (please attach)	**Comment / Result**
Has the patient consented to receiving rTMS if assessed as suitable and completed written consent?	YES / NO………………………………………
Has the patient completed the TMS Adult Safety Screen?	YES / NO………………………………………
Has the TT referral been completed for day patients?	YES / NO………………………………………

Referring Psychiatrist Name: ________________________________ **Date:**____________________

Referring Psychiatrist Signature: _____________________**Provider Number:**___________________

Please return to the Intake Officer via email: admissions@toowongprivatehospital.com.au or fax: 07 3721 8015