BrainSave TMS

Transcranial Magnetic Stimulation Referral Form

Patient details

Name _____ DOB _____ Gender ☐ M ☐ F

Address _____

Contact number _____ Email _____

Medicare number _____ Individual ref. _____

Health fund/work cover/DVA _____ Membership number _____

Referral information

Reasons for TMS referral

☐ Major depressive disorder ☐ Chronic pain ☐ GAD ☐ OCD ☐ PTSD ☐ Tinnitus

☐ Panic disorder ☐ Other (please specify) _____

Medications and clinical notes

In the last 12 months has the patient:

☐ trialled 2 or more classes of antidepressants, if so please specify: _____

☐ been admitted for psychiatric condition **or** ☐ is currently admitted at: _____

Additional information (include comorbidities, current medication(s) and previous antidepressants trialled if applicable)

_____

_____

_____

Requesting doctor

☐ Psychiatrist ☐ GP ☐ Other: _____

Name _____

Practice address _____

Provider no. _____

Contact number _____

Email _____

Doctor's signature _____

Date _____

Optional: doctor/clinic stamp

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