Best Brains and Minds
Specialist Clinic

TMS Online Referral Form

Direct Referral for Transcranial Magnetic Stimulation (TMS)

Patient Details

First Name_____

Surname_____

Date of Birth: (DD/MM/YYYY)_____

Address:_____

Suburb:_____State:_____

Post Code;_____Phone:_____

Email:_____

Current status: (please tick)

☐ Inpatient ☐ Outpatient

Indication for TMS

☐ Depression ☐ OCD ☐ PTSD ☐ Pain ☐ Other

Main reason for Treatment: (please tick)

☐ Minimal to no response to medication

☐ Previous good response to TMS

☐ Poor tolerability to medications (side effects)

☐ Other (specify)

Has the patient undergone any previous neurostimulation (i.e. rTMS or ECT)?

☐ Yes ☐ No

Other concurrent treatment(s):

☐ Psychopharmacology ☐ Psychotherapy ☐ Coaching and Mentoring
☐ Exercise Physiology ☐ Other (please Specify)

Has the patient trialled at least 2 classes of antidepressants without satisfactory improvement?

☐ Yes ☐ No ☐ Not Clinically appropriate

Potential Risks:

☐ Epilepsy/Seizures ☐ Eye injury ☐ Pacemaker or other implantable device
☐ Neurosurgery ☐ Cochlear implant ☐ Previous problems with TMS
☐ Aggression/ Agitation ☐ Suicide attempts/suicidal ideation

Allergies/Other risks:

☐ No ☐ Yes (please specify)_____

Additional Information:_____

Referring Practitioner

Referrer's Name:_____

Provider Number:_____

Practice Address:_____

_____

Contact No:_____

Email:_____

Referrer Type:

☐ General Practitioner (GP) ☐ Psychiatrist
☐ Other Specialist Doctor ☐ Allied Health Professional

Referrer's Signature:_____Date:_____