SYDNEY TMS

Transcranial Magnetic Stimulation

Transcranial Magnetic Stimulation Referral Form

(Please discuss this treatment with your doctor and ask them to complete this form)

Referring Doctor

Name _____

Address _____

Contact number _____ Provider number _____

Patient Details

Name _____

Date of Birth _____/_____/_____ Gender ☐ Male ☐ Female

Address _____

Contact number _____ Email _____

Reason for Referral

Medical condition that may affect TMS treatment.

History of seizures		Metal pins or plates to head	
Head Injury		Pacemaker	
Neuro Surgery		Other medical pumps or stimulators	
Implant to head or neck		Cochlear Implants	

❖ If any of the above if ticked, please provide additional information

Doctor's Signature _____ **Date** _____

Provider Number _____

T: 1300177144 info@sydneytms.com.au www.sydneytms.com.au