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 is ticked, please provide additional information

Provider Number

Date

Doctor's Signature

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