TMS
GOLD COAST
Transcranial Magnetic Stimulation

REFERRAL FORM

Patient Details

Name

Date of Birth | Gender

Address

Contact number | Email

Medicare No | Health Fund

Work Cover No | DVA No

Treatment History

Current Medication

Past Anti-Depressants

TMS Specific Information

Have you used TMS before? ☐ | If yes, when?

Have you had ECT before? ☐ | If yes, when?

Relevant Medical Conditions (Please tick)

Epilepsy ☐ | Pacemaker ☐ | Metallic Implants ☐ | Eye Injuries ☐

Head Injury ☐ | Neurosurgery ☐ | Cochlear Implants ☐ | Other:

Referring Doctor

Name

Address

Contact No | Provider No

Doctors Signature | Date

Please send referrals to admin@tmsgoldcoast.com OR fax to 3905 1839