Please fax referral to 780-342-5682
For further inquiries please call 780-342-5675

rTMS Referral

Name of Referring Physician: _____ PRACID #_____

Referral Site: _____ Ph #: _____ Fax: _____

Client has Community Mental Health Supports in place? MHT? YES☐ NO ☐ Psychiatrist? YES☐ NO ☐

Patient Information			
Name		**Sex**	
DOB		**PHN**	
Phone #		**Address**	
Diagnosis			

* rTMS therapy will begin with a focus on the initial introductory indications for the **primary diagnosis of Treatment Resistant Major Depressive Disorder only.** (Referrals for Treatment Resistant Bipolar Disorder are not accepted at this time).

Patient Screening Information *(To be completed by Physician)*

(in order to avoid time delays, please ensure the following questions have been completed with the patient. Indicate Yes or No).

YES☐ NO☐ Does the patient have a history of epileptic seizures?
YES☐ NO☐ Does the patient have any first degree relatives with idiopathic epilepsy?
YES☐ NO☐ Does the patient have a history of cardiac disease? If Yes, please specify
YES☐ NO☐ Does the patient have a history of spinal injury?
YES☐ NO☐ Does the patient have a history of frequent or severe headaches?
YES☐ NO☐ Does the patient have a have a personality disorder?
YES☐ NO☐ Does the patient have a history of suicidal attempts? If Yes, please indicate when and provide any notes available.
YES☐ NO☐ Is the patient currently suicidal?
YES☐ NO☐ Has the patient EVER been a grinder, metal worker, or welder?
YES☐ NO☐ Has the patient EVER had a metal foreign body in their eye? If yes, please provide an orbital x-Ray report prior to appt
YES☐ NO☐ If the patient is a female, is there a chance the patient may be pregnant? Indicate date of last menstrual period_____

YES☐ NO☐ Cardiac pacemaker
YES☐ NO☐ Aneurysm clip
YES☐ NO☐ Neurostimulator
YES☐ NO☐ Cochlear implants
YES☐ NO☐ Medication infusion device
YES☐ NO☐ Other implanted device(s) or metallic objects in body
YES☐ NO☐ Is there any history of either alcohol or drug abuse?
YES☐ NO☐ Has the patient ever had an MRI?
YES☐ NO☐ Has the patient been informed about rTMS and associated risks?

Has the patient had previous:

YES☐ NO☐ rTMS
YES☐ NO☐ tDCS
YES☐ NO☐ ECT
YES☐ NO☐ VNS
YES☐ NO☐ DBS

Note: Anticonvulsants may interfere with rTMS and should normally be discontinued at least 4 weeks prior to starting treatment unless the patient has a seizure disorder. All patients must be on stable medication regimen for at least 4 weeks before starting rTMS.

Please Attach:
CLINICAL HISTORY (Include past psychotherapy trials and outcomes)
PAST MEDICATION TRIALS & CURRENT MEDICATIONS

_____ _____
Date of Referral Signature of Referring Physician