rTMS Clinic, Perron Institute
8 Verdun Street, Nedlands, WA 6009
Ph: (08) 6457 0200, Fax: (08) 6457 0281
Return form to tms@perron.uwa.edu.au

rTMS Clinic Referral Form

Patient Details		
Name:	**Age:**	**DOB:**
Contact Number:	**Primary diagnosis:**	
Email:	**Address:**	
Medicare details:		

Current status:

☐ Inpatient ☐ Outpatient

Main reason for rTMS treatment referral (select all that apply):

☐ Minimal to no response to medication ☐ Poor tolerability to medication

Have they had brain stimulation in the past:

☐ Yes, rTMS, please specify when and how many: _____

☐ Yes, ECT, please specify when and how many: _____

☐ No

Have they adequately trialled at least 2 antidepressants without satisfactory improvement?

☐ Yes, please specify how many: _____ ☐ No

Have they undergone psychological therapy?

☐ Yes, in the past but no longer ☐ Yes, currently ☐ No

Do they meet any of the following potential risks:

☐ Epilepsy/history of seizures ☐ Eye injuries ☐ Pacemaker/other implants

☐ Neurosurgery ☐ Cochlear implant ☐ Suicide

Please list if any allergies:

Please list all psychiatric and medical conditions:

Referrer Details	
Name:	**Provider number:**
Practice Name and Adress:	
Email:	**Contact number:**
Signature:	**Date:**

*****Please attach to this referral a list of all current medications including dosages, past medical history, previous EEGs, head CTs, MRI brain or other neuroimaging reports. *If not done in last 6 weeks, a blood test* (inc. full blood count, urea and electrolytes, liver function test, thyroid function test, calcium, vitamin D, vitamin B12, folate and iron studies) *is requested please.* Results of blood test are required PRIOR to assessment for consideration of rTMS treatment.*****