DO NOT WRITE IN THIS BINDING

OUTPATIENT rTMS REFERRAL

| | |
|---|---|
| THE TOOWOOMBA CLINIC<br>**rTMS Outpatient Referral Form** | Surname_____ UR Number_____<br>Given Name_____<br>Address_____<br>Postcode_____ DOB_____<br>Sex Male/Female Doctor_____<br>**Affix ID Label Here**<br>**For Toowoomba Clinic office use only.** |

| **Patient details** | | | |
|---|---|---|---|
| Name | | | |
| Date of Birth | | Gender | |
| Address | | | |
| Phone | | Email | |
| **Referring Doctor** | | | |
| Name | | | |
| Address | | | |
| Contact No. | | Provider No. | |
| Signature | | Date | |

| **Reason for referral** | | |
|---|---|---|
| Major Depressive Disorder ☐ | Obsessive-Compulsive Disorder ☐ | Auditory Hallucinations ☐ |
| Other (please describe): ☐ | | |

**Relevant Psychiatric and Medical History** Please attach additional pages if required.

**Current Medications** Please attach additional pages if required.

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| **Eligibility for Medicare Rebate** | | |
|---|---|---|
| Medicare Number: | Valid until: | |
| 18yrs or older | ☐ Yes | ☐ No |
| Diagnosed with major depressive disorder | ☐ Yes | ☐ No |
| No satisfactory response to two classes of antidepressant medications | ☐ Yes | ☐ No |
| Received psychological therapy | ☐ Yes | ☐ No |

*Please note that patients can be referred for obsessive-compulsive disorder, or auditory hallucinations for schizophrenia, but will not qualify for Medicare rebates.

| **rTMS Outpatient Safety Screen** | | |
|---|---|---|
| **1.** Has the patient undergone rTMS in the past? | ☐ Yes | ☐ No |
| **2.** Does the patient have a history of seizure/s? | ☐ Yes | ☐ No |
| **3.** Does the patient have metal in their head? | ☐ Yes | ☐ No |
| **4.** Does the patient have a cardiac pacemaker? | ☐ Yes | ☐ No |
| **5.** Does the patient have an implanted neurostimulation device (e.g.DBS, epidural or subdural, Vagus Nerve Stimulator)? | ☐ Yes | ☐ No |
| **6.** Does the patient have cochlear implants? | ☐ Yes | ☐ No |

Please send completed referrals to admin@thetoowoombaclinic.com.au

or by fax on (07) 4573 4409

One of our team will contact your patient to answer any questions they may have and to book their initial appointment. You will receive a confirmation letter about your referral and the patient's treatment.

If you have any questions, please call (07) 4573 4400, or email the address above.