Hobart **TMS**
Transcranial Magnetic Stimulation

TMS Referral Form

Patient Information

First Name ..... Last Name .....

Address .....

Suburb ..... Postcode ..... D.O.B .....

Phone ..... Email .....

Private Health Insurance Yes No Fund .....

Presenting problems (including diagnosis)

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Reason for referral

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Brief risk assessment

	Low	*Moderate*	*Severe*	*Unknown*
Suicidal/Self Harm				
Violence/Aggression				
Substance Abuse/Dependency				
Medical Risks				

Medical condition that may affect TMS treatment (please tick any that apply)

- ☐ Epilepsy
- ☐ Cardiac pacemaker
- ☐ Intracranial metallic objects

*If any of the above are indicated, please supply additional information.

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Referring doctor

Doctor's name ..... Provider number .....

Address .....

Phone ..... Email .....

Signature ..... Date .....