Referral Connected Minds TMS

Date: _____

Referring GP Practice: _____

Patient Name: _____

DOB: _____

Address: _____

Phone number: _____

Medicare number/row:_____

History of seizure: Y/N
Pregnant: Y/N
Significant alcohol use: Y/N
Medical implants: Y/N
Previous psychotherapy/counselling: Y/N
Previous trial of 2 different antidepressant medications: Y/N
DVA: Y/N
Private Health Fund: Y/N

I am requesting an assessment by one of your psychiatrists for an opinion regarding this individuals suitability for TMS treatment of a depressive illness.

Dr. _____

Signed: _____

Provider number: _____

Please send completed referral form to admin@connectedmindstms.com and we will contact the individual to arrange an assessment

0411020053
1/257 Oxley Avenue, Margate
www.connectedmindstms.com
admin@connectedmindstms.com