



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 a referral form to admin@connectedmindstms.com or find us under medical objects by searching for "Connected Minds TMS" and we will contact the individual to arrange an assessment

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