PH: 204-414-0077 FX: 204-417-5266

BrainWave Clinic rTMS Referral Form (please fax to 204-417-5266)

Referral Date: _____

Patient's name: _____ Date of Birth (DD/MMM/YY): _____

MHSC #: _____ PHIN #:_____

Address: _____

☐ Home Phone: _____ ☐ Work Phone: _____ ☐ Cell Phone/Other: _____

Is the patient currently suffering from:

☐ Treatment-Resistant Depression

Please describe the patient's **current clinical history, including past treatment trials:**

Please list all **current medications and dosages:**

Please list the patient's **complete past medical history:**

Do any of the following apply to the patient:

☐ Yes No ☐ Previous trial of rTMS (If yes, please identify which clinic and attach documents if available.)
☐ Yes No ☐ Previous trial of ECT (electroconvulsive therapy)
☐ Yes No ☐ History of seizures in patient or 1st degree relative
☐ Yes No ☐ Head injury or brain-related condition
☐ Yes No ☐ Metal plate, implant, or fragment in the head
☐ Yes No ☐ Current suicidal thoughts
☐ Yes No ☐ Active substance use/abuse, including EtOH, cannabis
☐ Yes No ☐ Willing and able to participate in a daily treatment for up to 6 weeks
☐ Yes No ☐ Voluntary and able to consent to treatment
☐ Yes No ☐ Past psychiatric assessment (If yes, please attach to this form.)

Referring Provider: _____ Phone: _____ Signature: _____