1-1171 Bedford Hwy, Bedford NS
902.466.ANSR (2677)
902.455.ANSR (2677)

rTMS REFERRAL FORM
PLEASE FAX TO 902-455-2677

Patient Information

Full Name: _____ _____ **DOB:**_____
Last First

Address: _____ _____ **Phone:**_____
Street City

History

Indication for rTMS
(please check all that apply):

- ☐ Major Depressive Disorder
- ☐ Bipolar Disorder
- ☐ Posttraumatic Stress Disorder
- ☐ Chronic Pain Syndrome
- ☐ Other:

Current Medications and doses:

Past Medication Trials:

Brief Clinical History

Potential Contraindications to rTMS

- ☐ History of Seizures
- ☐ History of Syncope
- ☐ Implanted pacemaker
- ☐ Cochlear Implant
- ☐ Cerebral aneurysm clip/coil
- ☐ Metal fragment in eye
- ☐ Pregnancy
- ☐ Unstable Medical Disorder
- ☐ Family history of epilepsy
- ☐ Head Trauma
- ☐ Cardiac disease or arrhythmia
- ☐ DBS or implanted device
- ☐ Medication infusion pump
- ☐ Metallic implant/foreign body
- ☐ Spinal Surgery
- ☐ Vulnerability of hearing

If yes to any of the above please elaborate to the right:

Physician Information

Name: _____ **Signature:** _____

Date: _____ **Phone:** _____