MIND WAVE TMS

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Mind Wave TMS Clinic

Transcranial Magnetic Stimulation

Referral Form

Patient Details:

Surname:		Name:	
Date of Birth:	/ /	Gender:	M F Non-Binary
Address:			
Suburb:		Postcode:	
Email:		Mobile:	
Medicare No:	☐☐☐☐ – ☐☐☐☐☐ – ☐	Ref no.	☐

Referring Doctor:

Name:			
Practice Name:			
Address:			
Suburb:		Postcode:	
Contact No:		Provider No:	

Stamp if prefer

Mind Wave TMS Clinic

Reason for Referral

Medical Condition(s) which may affect TMS Treatment:

History of Seizures:		Metal Pins or Plates to Head	
Head Injury		Pacemaker	
Neurosurgery		Other Metal Plates or Stimulators	
Implant to Head or Neck		Cochlear Implants	

Other

If any of the above are ticked, please provide additional information:

Doctor Signature:…… Date: ……