

NINET-IMH CLINIC

Request for Consultation

Patient Identification:

Name: _____
 Birthdate: _____
 PHN: _____
 Tel: _____ Alt Tel: _____
 Email: _____
 Address: _____

Referring Physician:

Name: _____
 Billing #: _____
 Tel: _____
 Fax: _____
 Email: _____
 Address: _____

Indication for rTMS:

- ☐ Major Depressive Disorder
- ☐ Bipolar Disorder
- ☐ Obsessive-Compulsive Disorder
- ☐ Psychosis
- ☐ Other: _____

Current Medications and Doses:

Brief Clinical History/Comorbid Medical Issues:

Potential Contraindications to rTMS

- ☐ Y ☐ N History of epileptic seizures
- ☐ Y ☐ N Family history of epilepsy
- ☐ Y ☐ N History of syncopal episodes
- ☐ Y ☐ N Head trauma with loss of consciousness
- ☐ Y ☐ N Cardiac disease
- ☐ Y ☐ N Cardiac arrhythmia
- ☐ Y ☐ N Implanted cardiac pacemaker or defibrillator
- ☐ Y ☐ N Implanted DBS or other neurostimulator
- ☐ Y ☐ N Cochlear implant
- ☐ Y ☐ N Medication infusion device
- ☐ Y ☐ N Aneurysm clip or coils
- ☐ Y ☐ N Metallic implant or other foreign body
- ☐ Y ☐ N Metal fragments in eye/history of metal work
- ☐ Y ☐ N History of spinal surgery
- ☐ Y ☐ N Impairment or vulnerability of hearing
- ☐ Y ☐ N Pregnant

Previous: ☐ rTMS ☐ tDCS ☐ ECT ☐ VNS ☐ DBS

Date of Referral: _____ Signature of Referring Physician: _____

Please fax all consultation requests to the attention of:
NINET LAB - Fidel Vila-Rodriguez, MD, FRCPC, FAPA
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