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:

_____
_____
_____
_____
_____
_____
_____
_____
_____

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

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**

Date of Referral: _____ **Signature of Referring Physician**:_____

Please fax all consultation requests to the attention of:

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