# The Sherpah Clinic

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# TMS Referral Form

## PATIENT DETAILS

| | | | |
|---|---|---|---|
| Name | | | |
| Address | | | |
| DOB | | Medicare # | |
| Telephone (H) | | Mobile | |
| Email | | | |
| Medicare # | Expiry: / | | |

## INDICATION

- ☐ Depression
- ☐ PTSD
- ☐ OCD
- ☐ Pain
- ☐ Other

## CLINICAL DETAILS

## CURRENT AND PAST MEDICATION/S

## CONDITIONS THAT MAY AFFECT TMS TREATMENT

- ☐ Epilepsy or Past Seizures
- ☐ Neurosurgery
- ☐ Cochlear Implant
- ☐ Implantable Medical Devices
- ☐ Pacemaker

## REFERRING PRACTITIONER

| | | | |
|---|---|---|---|
| Name | | | |
| Practice | | | |
| Address | | | |
| Phone | | Provider Number | |
| Signature | | Date | |