

rTMS Centre of Excellence:
A Collaboration of MCC and CAMH
 340 College Street, Suite 405
 Toronto, ON M5T 3A9
 Local: 647-344-RTMS (7867)
 Fax: 647-259-7869



PATIENT REFERRAL

- Psychiatric Assessment
- rTMS Therapy
- Disease State(s): _____

Patient Name _____
Caretaker _____
Address _____
City _____ Prov/State _____
Postal/Zip _____ Country _____
Tel () _____
DOB _____ Sex _____
YYYY/MM/DD

Doctor Name _____
Address _____
City _____ Prov/State _____
Postal/Zip _____ Country _____
Tel () _____
Fax () _____
Email _____

PATIENT SCREENING INFORMATION

(In order to avoid time delays, please ensure the following questions have been completed with the patient).

YES NO

- 1. Has the patient ever been a grinder, metal worker or welder?
- 2. Has the patient EVER had a metal foreign body in their eye?
If yes, please provide an orbital x-ray report prior to appt.
- 3. Is there a chance the patient may be pregnant? Indicate date of last menstrual period _____.
- 4. Does the patient have any of the following?
 - Cardiac pacemaker
 - Aneurysm clip
 - Neurostimulator
 - Cochlear implants
 - Other implanted device(s) or metallic objects in body
- 5. Does the patient or any first degree relative have idiopathic epilepsy?
- 6. Does the patient suffer from significant cardiac disease?
- 7. Is there any history of either alcohol or drug abuse?
- 8. Has the patient made any suicide attempts or is the patient currently suicidal?
If yes, please indicate when and provide any notes available.
- 9. Does the patient have any infectious diseases?
- 10. Does the patient have a personality disorder?

If the patient has answered YES to any of these questions, the doctor's office should call before submitting this requisition. Thank you.

CLINICAL HISTORY _____

MEDICATION/DOSAGE <input type="checkbox"/> tricyclics <input type="checkbox"/> bupropion _____

ALLERGIES _____

Signature _____ Date _____