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Healthy Minds. Better Lives.™



PATIENT REFERRAL

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

Patient Name _____
Care Taker _____
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 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 MindCare Centres before submitting this requisition. Thank you

CLINICAL HISTORY _____

MEDICATION/DOSAGE tricyclics bupropion _____

ALLERGIES _____

Signature _____ **Date** _____