brainWave clinic
PH: 204-414-0077 FX: 204-417-5266

BrainWave Clinic rTMS Referral Form (please fax to 204-417-5266)

Referral Date: _____

Patient's name: _____ Date of Birth (DD/MMM/YYYY): _____

MHSC #: _____ PHIN #:_____

Address: _____

☐ Home Phone: _____ ☐ Work Phone: _____ ☐ Cell Phone/Other: _____

Is the patient currently suffering from:

☐ Treatment-Resistant Depression

Please describe the patient's **current clinical history, including past treatment trials:**

Please list all **current medications and dosages:**

Please list the patient's **complete past medical history:**

Do any of the following apply to the patient:

☐ Yes ☐ No Another rTMS referral was / will be sent to another clinic at the same time as this referral
☐ Yes ☐ No Previous rTMS assessment or treatment (If yes, please identify which clinic and attach documents if available.)
☐ Yes ☐ No Previous trial of ECT (electroconvulsive therapy)
☐ Yes ☐ No History of seizures in patient or 1st degree relative
☐ Yes ☐ No Head injury or brain-related condition
☐ Yes ☐ No Metal plate, implant, or fragment in the head
☐ Yes ☐ No Current suicidal thoughts
☐ Yes ☐ No Active substance use/abuse, including EtOH, cannabis, etc. (If yes, please state which substances.)
☐ Yes ☐ No Willing to participate in daily treatments for up to 6 weeks
☐ Yes ☐ No Voluntary and able to consent to treatment
☐ Yes ☐ No Past psychiatric assessment (If yes, please attach to this form.)

Referring Provider: _____ Phone: _____ Signature: _____