ABN 76 664 676 420
Address: 151 Smith St, Southport QLD 4215
Phone: 07 5662 3883
Website: brainaidclinics.com
Email: info@brainaidclinics.com

Referral for Evaluation of Transcranial Magnetic Stimulation Suitability

PATIENT DETAILS

Full Name:

Address:

DOB:

Medicare No Ref: Valid Until

Preferred method of contact

Complete if your patient consents to our Patient Care Team contacting them directly to book an appointment.

☐ Mobile ☐ Email

Alternative Contact

Please provide the details of someone whom our Patient Care Team can contact if we are unable to reach you.

Name Phone Number

Relationship

Health fund

Fund: ☐ Self-funded ☐ Department of Veteran Affairs

☐ Funding ☐ TAC ☐ Worker's Comp

☐ Medicare

Membership / claim number:

Case Manager Contact Number

REFERRING DOCTOR

☐ Psychiatrist ☐ GP ☐ Other:

Name

Optional: doctor / clinic stamp

Provider number

Practice Address

Direct Email (not reception)

Mobile Number:

Doctor's Signature

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Referral for Evaluation of Transcranial Magnetic Stimulation Suitability

REFERRAL DETAILS

Reason for Referral:
(Please provide a brief summary of the patient's mental health condition and the reason for referral to evaluate their suitability to receive Transcranial Magnetic Stimulation (TMS) therapy)

Previous Treatments:
(Please list any previous mental health treatments the patient has undergone, including medications, therapies, and hospitalizations, if applicable)

Additional Comments/Concerns:
(Include any additional information or concerns you believe are pertinent for the evaluation of the patient's suitability for TMS therapy. Note that this referral is for evaluation purposes and not immediate TMS treatment.)