

## TMS REFERRAL FORM PLEASE FAX TO 902-455-2677

Last       First       M.I.         Address:	Patient Information				
Last       First       M.I.         Address:	Full Name:	Jame:		DOB:	
Street Address       City       Phone         History         Indication for TMS       Current Medications and Doses:         (please check all that apply):       Current Medications and Doses:         Major Depressive Disorder       Disorder         Posttraumatic Stress Disorder       Disorder         Other:       Brief Clinical History (please attach any available reports)         Brief Clinical History (please attach any available reports)         Potential Contraindications to TMS         History of Epileptic Seizures       Family history of epilepsy         History of Syncope       Head Trauma         Implanted Pacemaker       Cardiac Disease or arrhythmia         Cardiac Disease or arrhythmia       DBS or implanted Device		First			
Street Address       City       Phone         History         Indication for TMS       Current Medications and Doses:         (please check all that apply):       Current Medications and Doses:         Major Depressive Disorder       Bipolar Disorder         Posttraumatic Stress Disorder       Chronic Pain Syndrome:         Other:       Brief Clinical History (please attach any available reports)         Potential Contraindications to TMS         History of Epileptic Seizures       Family history of epilepsy         History of Syncope       Head Trauma         Implanted Pacemaker       Cardiac Disease or arrhythmia         Cardiac Disease or arrhythmia       DBS or implanted Device	Address:				
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Posttraumatic Stress Disorder Chronic Pain Syndrome: Other: Brief Clinical History (please attach any available reports)  Potential Contraindications to TMS  Potential Contraindications to TMS  History of Epileptic Seizures Family history of epilepsy History of Syncope Head Trauma Head Trauma Head Trauma Dess or implant Cerebral aneurysm DBS or implanted Device					
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	Cochlear Implant	arrhythmia			
		-	5		
Unstable Medical Disorder UVUINERABILITY of Hearing If yes to any of the above please elaborate to the right:			9		
Physician Information					
Name:Signature:					
Date: Phone:	Date:	Phone:			

\*TMS is not currently covered by the Nova Scotia Health Plan (MSI)