ANSR

Unit 1 - 2751 Gladstone Street Halifax NS
902.466.ANSR (2677) phone
902.455.ANSR (2677) fax

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

## Patient Information

Full Name: _____ DOB: _____
*Last* *First* *M.I.*

Address: _____
*Street Address* *City* *Phone*

## History

Indication for TMS
(please check all that apply):

- ☐ Major Depressive Disorder
- ☐ Bipolar Disorder
- ☐ Posttraumatic Stress Disorder
- ☐ Chronic Pain Syndrome:
- ☐ Other:

Current Medications and Doses:

## Brief Clinical History (please attach any available reports)

## Potential Contraindications to TMS

- ☐ History of Epileptic Seizures
- ☐ History of Syncope
- ☐ Implanted Pacemaker
- ☐ Cochlear Implant
- ☐ Cerebral aneurysm clip/coil
- ☐ Metal fragment in eye
- ☐ Pregnancy
- ☐ Suicidality
- ☐ Unstable Medical Disorder
- ☐ Family history of epilepsy
- ☐ Head Trauma
- ☐ Cardiac Disease or arrhythmia
- ☐ DBS or implanted Device
- ☐ Medication Infusion Pump
- ☐ Metallic Implant/Foreign Body
- ☐ Spinal Surgery
- ☐ Vulnerability of Hearing

***If yes to any of the above please elaborate to the right:***

## Physician Information

*Name:*_____ *Signature:* _____

*Date:* _____ *Phone:* _____

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