rTMS Clinic
EXTERNAL REQUEST FOR CONSULTATION

Please send all consultation requests to the attention of:
rTMS Clinic
Access Mental Health | Fax: 403-943-9044

Note: Anticonvulsants, benzodiazepines and sleep medications (e.g.. Zopiclone) may interfere with rTMS and should normally be discontinued at least 4 weeks prior to starting treatment.

All patients must be on stable medication regimen for at least 4 weeks before starting rTMS.

PATIENT IDENTIFICATION

Name

Sex

DOB

AHC#

Address

City

Postal Code

Telephone

Email

REFERRING PHYSICIAN

Name

PRACID#

Clinic Name

Address

City Prov

Postal Code

Telephone

Fax

Email

PATIENT SCREENING INFORMATION

(In order to avoid time delays, please ensure the following questions have been completed with the patient. (Please check one, YES or NO).

YES	NO	***Is patient able to attend daily rTMS treatments for 6 consecutive weeks?***
YES	NO	1. Does the patient have a history of epileptic seizures?
YES	NO	2. Does the patient have a history of syncope episodes?
YES	NO	3. Has the patient ever had a manic/hypomanic episode?

YES	NO	4. Does the patient have a history of cardiac disease?
		If yes, please specify

YES	NO	5. Does the patient have a history of spinal surgery?
YES	NO	6. Does the patient have a history of frequent or severe headaches
YES	NO	7. Does the patient have a Personality Disorder?
YES	NO	8. Does your patient have a criminal history?
YES	NO	9. Does the patient have a history of suicidal attempts?
		If Yes, please indicate when and provide any available notes.

YES	NO	10 Is the patient currently suicidal?
YES	NO	11. Is there a history of either drug of alcohol abuse; cocaine, cannabis, amphetamine use (prescribed or not)?
		Please specify drugs used and when patient last used drugs or alcohol.

YES	NO	12. Has the patient EVER been a metal grinder, metal worker or welder?
YES	NO	13. Has the patient EVER had a metal foreign body in their eye?
		If Yes, please provide an orbital x-ray report prior to appt.
YES	NO	14. If the patient is a female, is there a chance the patient may be pregnant?
YES	NO	15. Is the patient currently experiencing psychosis?
		16. Does the patient have any of the following?
YES	NO	Cardiac pacemaker
YES	NO	Aneurysm clip
YES	NO	Neurostimulator

YES	NO	Cochlear implants
YES	NO	Medication infusion device
YES	NO	Other implanted device(s) or metallic objects in the body
YES	NO	17. Does the patient have any infectious disease?
YES	NO	18. Has the patient ever had an MRI?
		19. Has the patient had previous:
YES	NO	rTMS
YES	NO	ECT
YES	NO	20. Is the patient under WCB?
YES	NO	21. Is this an insurance claim?

MUST PROVIDE A FULL HISTORY INCLUDING A CURRENT DIAGNOSIS

(Attach recent consults and mental health assessments including SCM and/or Netcare)

Include psychotherapy trials and outcomes

CURRENT MEDICATIONS/SUPPLEMENTS DOSES/FREQUENCY

Date of Referral

Signature of Referring Physician