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Magnetic Potential
ACCELERATED TMS THERAPY

Transcranial Magnetic Stimulation (TMS) Referral Form

Referring Doctor: _____ Fax #:_____Phone #: _____

Signature: _____ Date (DD/MM/YYYY):_____

Patient's Name: _____
Surname First Name Middle Name

Date of Birth (DD/MM/YYYY): _____ Phone #:_____

PHN#: _____

Address: _____ City:_____ Postal Code:_____

Diagnosis: _____

Do any of the following apply to the patient: (If yes, please describe or attach additional information.)

Yes☐ No☐ Currently suffering from a major depressive episode according to the DSM V criteria
Yes☐ No☐ Failed to respond to two treatments with adequate dose and duration (treatment can include a course of psychotherapy)
Yes☐ No☐ History of seizures in patient or 1st degree relative
Yes☐ No☐ Current suicidal thoughts
Yes☐ No☐ Substance use/abuse, including EtOH, cannabis
Yes☐ No☐ Prepared to allow follow up contact via email/phone/text post-treatment

Note: please attach a consult letter describing current medication including past trials and reasons for discontinuation. Also please attach any other relevant reports or documents.