rTMS Clinic
EXTERNAL REQUEST FOR CONSULTATION

Please send all consultation requests to the attention of:
rTMS Clinic Rockyview General Hospital
Fax: 403-592-4276

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 a stable medication regimen for at least 4 weeks before starting rTMS.

PATIENT IDENTIFICATION	**REFERRING PHYSICIAN**
Name	Name
Sex	PRACID#
DOB	Clinic Name
AHC#	Address
Address	City Prov AB
City	Postal Code
Postal Code	Telephone
Telephone	Fax
Email	Email

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

Height of patient _____

Current weight of patient _____

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