

Patient Information

First Name Last Name

Address

Suburb Postcode D.O.B

Phone Email

Private Health Insurance Yes No Fund

Presenting problems (including diagnosis)

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Reason for referral

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Brief risk assessment

	<i>Low</i>	<i>Moderate</i>	<i>Severe</i>	<i>Unknown</i>
Suicidal/Self Harm				
Violence/Aggression				
Substance Abuse/Dependency				
Medical Risks				

Medical condition that may affect TMS treatment (please tick any that apply)

- Epilepsy
- Cardiac pacemaker
- Intracranial metallic objects

*If any of the above are indicated, please supply additional information.

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Referring doctor

Doctor's name Provider number

Signature Date