

## Patient Details

Name: .....

Date of Birth: ..... Gender:  Male  Female

Address: .....

Contact Number: ..... Email: .....

Medicare Number: .....

Health Fund: ..... Membership Number: .....

## Clinical Notes

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### Details of medication trials conducted in the last 12 months

Medication/s name:	Date Commenced	Dose (range)	Duration (weeks):

## Medical conditions that may affect TMS treatment

- Epilepsy     
  Pacemaker     
  Implantable medical pumps or stimulators  
 Eye injuries     
  Neurosurgery     
  Cochlear Implants

If any of the above is ticked, please provide additional information

## Referring Doctor

Name: .....

Address: .....

Contact Number: ..... Provider Number: .....

Doctor's Signature: ..... Date: .....