VivaMinds

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rTMS referral

Please complete and email to **info@vivamindstms.com**. Attach recent clinical notes or correspondence if available. We will confirm receipt and arrange a psychiatrist assessment.

REFERRING PRACTITIONER

Name _____ Provider number _____

Practice _____ Phone _____

Email _____ Fax _____

I am a ☐ General practitioner ☐ Psychiatrist ☐ Other

PATIENT

Full name _____ Date of birth _____

Address _____

Phone _____ Email _____

Medicare number _____ IRN _____ DVA / WorkCover no. _____

CLINICAL INFORMATION

Diagnosis _____ Duration of current episode _____

Antidepressant trials (at least two different classes required for Medicare-funded rTMS)

Antidepressant	Class	Dose	Duration	Response / reason stopped

Has the patient undertaken psychological therapy? ☐ Yes ☐ No

If yes, type and duration _____

Has the patient previously received TMS treatment? ☐ Yes ☐ No

SAFETY SCREENING

History of seizures or epilepsy	☐ Yes	☐ No
Metal in the head or neck (excluding dental fillings), cochlear implant or aneurysm clips	☐ Yes	☐ No
Implanted device, e.g. pacemaker, deep brain or vagus nerve stimulator	☐ Yes	☐ No
Significant head injury, stroke or other neurological condition	☐ Yes	☐ No
Pregnant or planning pregnancy	☐ Yes	☐ No
Current substance or alcohol misuse	☐ Yes	☐ No
Current suicide risk requiring urgent assessment	☐ Yes	☐ No

If the patient is at immediate risk, do not send this referral alone. Arrange urgent care through acute mental health services (1300 642 255) or call 000.

CURRENT MEDICATIONS AND OTHER RELEVANT HISTORY

REFERRAL

I refer this patient for psychiatric assessment and, if clinically appropriate, repetitive transcranial magnetic stimulation (rTMS).

Signature _____ Date _____

This referral is valid for 12 months from the date of issue unless otherwise stated.