NORTH COAST TMS
TRANSCRANIAL MAGNETIC STIMULATION

CLINICIAN REFERRAL

Repetitive Transcranial Magnetic Stimulation (rTMS)

CONFIDENTIAL

Please complete all relevant sections and attach supporting clinical information where available.

1 REFERRING CLINICIAN

CLINICIAN NAME | PROVIDER NUMBER | PHONE

PRACTICE / CLINIC | EMAIL

PRACTICE ADDRESS | STATE | POSTCODE

2 PATIENT INFORMATION

FULL NAME | DATE OF BIRTH | GENDER / PRONOUNS

RESIDENTIAL ADDRESS

SUBURB / TOWN | STATE | POSTCODE | PHONE

EMAIL | MEDICARE NUMBER | IRN | EXPIRY

3 REFERRAL DETAILS

FUNDING

☐ Medicare ☐ Self-funded ☐ DVA

☐ WorkCover ☐ Private health

EMERGENCY CONTACT

NAME | RELATIONSHIP | PHONE

INDICATION(S) / REASON FOR REFERRAL

☐ Major depressive disorder ☐ Generalised anxiety

☐ Obsessive-compulsive disorder ☐ PTSD

☐ Other

4 CLINICAL SUMMARY

PROVISIONAL DIAGNOSIS, CLINICAL HISTORY, CURRENT RISKS AND RELEVANT CONTEXT

5 TREATMENT HISTORY

Adequate trials of at least two antidepressant classes? ○ Yes ○ No

Previous TMS / rTMS? ○ Yes ○ No

Psychological therapy undertaken? ○ Yes ○ No

Medication adherence formally assessed? ○ Yes ○ No

CURRENT MEDICATIONS (INCLUDING DOSE)

PAST ANTIDEPRESSANT TRIALS, DOSE, DURATION AND RESPONSE

6 REFERRER DECLARATION

☐ I confirm the information supplied is accurate to the best of my knowledge.

SIGNATURE / TYPED NAME | DATE | ATTACHMENTS

☐ Included

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SAFETY & ELIGIBILITY

Screening information for specialist assessment and treatment planning

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1 SAFETY SCREENING

Select Yes or No for each item. Any Yes response requires specialist review and details below; this checklist does not replace the psychiatrist assessment.

History of seizures or epilepsy	Yes No	Pregnant or possibly pregnant	Yes No
Implanted stimulator, medication pump, pacemaker or similar device	Yes No	Metal in the brain, skull, head or elsewhere in the body	Yes No
Neurological illness, neurosurgery or serious head trauma	Yes No	Significant cardiovascular disease	Yes No
Alcohol / illicit drug dependence or heavy current use	Yes No	Medication or other factor that may lower seizure threshold	Yes No

DETAILS FOR ANY YES RESPONSE, INCLUDING DEVICE TYPE / LOCATION AND RELEVANT MEDICATIONS

2 MBS INITIAL-COURSE SCREENING CHECKLIST

For initial-course Medicare screening only. Eligibility and billing must be confirmed by the treating psychiatrist against the current MBS item wording.

- ☐ Patient is at least 18 years of age.
- ☐ Major depressive episode has been diagnosed.
- ☐ Unsatisfactory improvement despite adequate trials of at least two antidepressant classes; adherence assessed and each trial at a recommended therapeutic dose for at least three weeks, with titration where clinically appropriate.
- ☐ Psychological therapy has been undertaken where clinically appropriate.
- ☐ No previous transcranial magnetic stimulation therapy in a public or private setting.

Reference: MBS item 14216. Confirm current requirements before claiming a Medicare benefit.

3 WHAT HAPPENS NEXT

1. **Referral triage**
   The clinic reviews the referral and contacts the patient for an initial phone screen and appointment planning.
2. **Psychiatrist assessment**
   Diagnosis, suitability, contraindications, treatment options and informed consent are reviewed.
3. **Mapping and motor threshold**
   Treatment coordinates and stimulation intensity are established before the first treatment course.
4. **Treatment course**
   Sessions are scheduled to the prescribed protocol, commonly several days each week, with progress monitoring.
5. **Review and future planning**
   Response is reviewed and any retreatment, maintenance or alternative plan is discussed with funding confirmed.

This pathway is indicative; the treating psychiatrist individualises assessment and treatment planning.