REQUEST FOR CONSULTATION
TRANSCRANIAL MAGNETIC STIMULATION (TMS)

PATIENT INFORMATION:	Last Name:	First Name:	
Date of Birth:	Age:	Address:	
City:	Prov:	PHN:	Out-of-province PHN # ☐ YES ☐ NO
Phone Number:		Email:	
Requires Interpreter ☐ YES ☐ NO	Language:	Gender M ☐ F ☐ Other ☐	

REFERRING PRACTITIONER & CLINIC INFORMATION:

☐ Family Doctor ☐ Nurse Practitioner ☐ Psychiatrist ☐ Other (Specify):	Name: PRACID # Address: Phone: Fax:

PATIENT SCREENING INFORMATION (Please complete as thoroughly as possible) :

1. Has the patient had a metallic foreign body in their eye? Yes ☐ No ☐
2. Does the patient have any of the following:
   a. Cardiac pacemaker or implanted defibrillator? Yes ☐ No ☐
   b. Cochlear Implants? Yes ☐ No ☐
   c. Neurostimulator? Yes ☐ No ☐
   d. Medication Infusion device? Yes ☐ No ☐
   e. Neurological illness, neurosurgery or serious head trauma? Yes ☐ No ☐
   f. Any other implanted device or metal object in their head/neck/chest? Yes ☐ No ☐
3. Does the patient have a history of seizures? Yes ☐ No ☐
4. Is there a chance that the patient could be pregnant? Yes ☐ No ☐

CLINICAL HISTORY/DIAGNOSES (attach, if necessary)

I support this patient in initiating TMS at Manor clinic. I have examined this patient and certify that, to the best of my knowledge, there is no other medical contraindication for undergoing TMS treatment. If special instructions are required, I have indicated those clearly above.

Please send the completed form to:

Manor Clinic
1107 127 Street SW Edmonton T6W 1A3 Alberta
Fax: 780-6662608 Email: admin@manorclinic.ca
Please contact Manor Clinic on 780-669-8555 if you have any questions.

Referrer's Signature:	Date:

WE WILL CONTACT YOUR PATIENT DIRECTLY

***REFERRAL LETTER WILL ALSO BE ACCEPTED IN LIEU OF MANOR CLINIC REFERRAL FORM**

Oct 2024