ANSR
Atlantic Neuromod Solutions and Rehabilitation

ansr.ca

rTMS REFERRAL FORM

Fax to: 902-455-2677
Email to: info@ansrclinic.com

PATIENT INFORMATION

FIRST NAME | LAST NAME | DATE OF BIRTH (DD/MM/YYYY)

ADDRESS | CITY | PROVINCE | POSTAL CODE

PHONE # (CELL) | PHONE # (HOME) | EMAIL ADDRESS

VETERAN ID OR HEALTH CARD # | PATIENT CARETAKER (IF APPLICABLE)

PREFERRED LOCATION: ☐ Bedford ☐ Fredericton ☐ St. John's ☐ Edmonton ☐ Calgary

MEDICAL HISTORY

INDICATIONS FOR rTMS:
(Please check all that apply)

- ☐ Major Depressive Disorder
- ☐ Bipolar Depression
- ☐ Posttraumatic Stress Disorder
- ☐ Other:

CURRENT MEDICATIONS AND DOSES: ☐ NONE

PAST MEDICATION TRIALS: ☐ NONE

BRIEF CLINICAL HISTORY (please include any known allergies)

POTENTIAL CONTRADICTIONS TO rTMS

☐ History of Seizures	☐ Pregnancy	☐ DBS or Implanted Device
☐ History of Syncope	☐ Unstable Medical Disorder	☐ Medication Infusion Pump
☐ Implanted Pacemaker	☐ Family History of Epilepsy	☐ Metallic Implant/Foreign Body
☐ Cochlear Implant	☐ Head Trauma	☐ Spinal Surgery
☐ Cerebral Aneurysm Clip/Coil	☐ Cardiac Disease or Arrhythmia	☐ Vulnerability of Hearing
☐ Metal Fragment in Eye		☐ Suicidality

If yes to any of the above, please elaborate:

PHYSICIAN / NP INFORMATION

NAME | SIGNATURE

DATE | PHONE #