



Patient Name: _____

Date of Birth: _____

PHN: _____

Practitioner: _____

Address: _____

PRACID: _____

Phone: _____

Phone #: _____

Email: _____

Fax #: _____

****PATIENT EMAIL ADDRESS IS REQUIRED****
or will automatically be declined

Repetitive Transcranial Magnetic Stimulation (rTMS) Referral Form

Patient Eligibility (must meet all criteria):

- Age 18+
- Diagnosis of major depressive disorder, post-traumatic stress disorder, obsessive-compulsive disorder, generalized anxiety disorder or depression secondary to traumatic brain injury/ concussion
- Has failed at least 3 antidepressant trials (non-response or intolerance)
- Not actively suicidal (requires higher level of care)
- No non-removable metallic hardware or devices in the head region (cochlear implants, deep brain stimulators, foreign metal fragments, etc.) - dental hardware is acceptable
- No prior history of epilepsy
- Depression and anxiety symptoms not deemed primarily caused by substance use
- No history of violence/ physical assault towards others
- No severe active substance use issues

Referral must include **both** of the following to be processed:

- recent clinical note pertaining to the reason for referral
- previous psychiatric consult notes (if available)
- (if applicable) patient is under the care of psychiatrist Dr. _____

Clinical background (personality traits, suicidality, diagnosis, comorbidities, patient goals):

Referring physician agrees to continue their care once patient has completed treatment at Reconnect Mental Health

Primary Care Provider Signature: _____ Date: _____