



Djavad Mowafaghian
CENTRE FOR BRAIN HEALTH



Interventional Neuropsychiatry Clinic



Request for Consultation

Patient Identification:

Name: _____
DOB: _____
PHN: _____
Phone(H): _____
Cell: _____
Email: _____
Address: _____

Referring Physician:

Name: _____
Billing #: _____
Tel: _____
Fax: _____
Email: _____
Address: _____

Family Doctor:

Name: _____
Billing #: _____
Tel: _____
Fax: _____
Email: _____
Address: _____

Occupation: _____

Current Medications and Doses:

Indication for rTMS/MST/ECT:

- Major Depressive Disorder
- Bipolar Disorder
- PTSD
- Psychosis
- Other: _____

Brief Clinical History/Comorbid Medical Issues:

Please provide recent reports.

Potential Contraindications to rTMS/MST/ECT:

- Y N History of epileptic seizures
- Y N Family history of epilepsy
- Y N History of syncopal episodes
- Y N Head trauma with loss of consciousness
- Y N Cardiac disease
- Y N Cardiac arrhythmia
- Y N Implanted cardiac pacemaker or defibrillator
- Y N Implanted DBS or other neurostimulator
- Y N Cochlear implant
- Y N Medication infusion device
- Y N Aneurysm clip or coils
- Y N Metallic implant or other foreign body
- Y N Metal fragments in eye/history of metal work
- Y N History of spinal surgery
- Y N Impairment or vulnerability of hearing
- Y N Pregnant

Are you referring the patient for: rTMS ECT ? Y N Allergy-Please attach a summary report

Date of Referral: _____ Signature of Referring Physician: _____

Please fax all consultation requests to the attention of
Interventional Neuropsychiatry Clinic

Michael Butterfield, MD, FRCPC | Fidel Vila-Rodriguez, MD, PhD, FRCPC FAPA | Jay Wang, MD, FRCPC

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