# Interventional Neuropsychiatry Clinic

## *Request for Consultation*

**Patient Identification:**

**Name:**______________________________
**DOB:**_______________________________
**PHN:**_______________________________
**Phone(H):** __________________________
**Cell:** ______________________________
**Email:**______________________________
**Address:**____________________________
______________________________________
**Occupation:** ________________________

**Referring Physician:**

**Name:** ______________________
**Billing #:** ___________________
**Tel:**_________________________
**Fax:** _______________________
**Email:** ______________________
**Address:** ____________________
_____________________________

**Family Doctor:**

**Name:** ______________________
**Billing #:** ___________________
**Tel:**________________________
**Fax:** _______________________
**Email:** ______________________
**Address:** ____________________
_____________________________

**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.
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**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**
- ☐Y ☐N **Allergy-Please attach a summary report**

**Are you referring the patient for: ☐rTMS ☐ECT ?**

______________________________________________________________________

**Date of Referral:** __________________ **Signature of Referring Physician**:____________________________

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