# RIVERVIEW MEDICAL SERVICES INC.

## rTMS PATIENT REFERRAL FORM

**Thank you for referring your patient for rTMS (repetitive Transcranial Magnetic Stimulation) therapy at Riverview Medical Services Inc. Please complete the required information listed below.**

| | |
|---|---|
| **Patient Name** | **Physician Name** |
| **Address** | **Address** |
| **City/Prov** | **City/Prov** |
| **Postal Code** | **Postal Code** |
| **Tel** | **Tel/Fax** |
| **DOB (yyyy/mm/dd)** | **Practice ID Number** |

**PATIENT SCREENING INFORMATION (Please complete the following questions with the patient):**

| | | |
|---|---|---|
| 1. Does the patient have a diagnosis of either Bipolar or Unipolardepression? | ☐ Yes | ☐ No |
| 2. Has the patient EVER had a metal foreign body in their eye? | ☐ Yes | ☐ No |
| 3 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) Any other implanted device or metal object in their body? | ☐ Yes | ☐ No |
| 4. Does the patient or any first degree relative have a history of seizures? | ☐ Yes | ☐ No |
| 5. Does the patient have any cardiac disease? | ☐ Yes | ☐ No |
| 6. Is there a chance that the patient could be pregnant? If so, date of LMP_____ | ☐ Yes | ☐ No |

**CLINICAL HISTORY/DIAGNOSES (attach detail as needed)**

**MEDICATIONS (attach list if necessary)**

**ALLERGIES**

Patient has been informed that rTMS is **NOT** covered by AlbertaHealth and Wellness and that the fee for treatment is the responsibility of the patient? ☐ Yes ☐ No

Date:_____ Signature:_____

Thank you for providing this information. **PLEASE FAX REFERRAL TO: 403-571-5167**
If you have any questions, please contact **Riverview Medical Services (403-571-5160)**

**Riverview Medical Services Inc.**
**Unit #312 - 4411 16 Avenue NW Calgary AB T3B 0M3**
**Phone: (403) 571-5160 Fax: (403) 571-5167**