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Dr Stubbeman
TMS PSYCHIATRY

PATIENT REFERRAL FORM

Referring Physician:	Phone:
Referral Date:	Email:
Patient's Name:	
Age:	Gender: ☐Male ☐Female
Would you prefer: ☐ Patient to call us at 424-248-3134 ☐ We call Patient. Patient Phone #: _____	

TMS SCREENING INFORMATION

Yes	No	
☐	☐	Is the Patient over 17 years old?
☐	☐	Does the Patient have a seizure disorder?
☐	☐	Does the Patient have a family history of seizure disorder?
☐	☐	Does the patient have any history of brain illness or brain tumor?
☐	☐	Does the Patient have any implanted metal device or object above the waist? (with exception of dental work)

CLINICAL INFORMATION

Reason for Referral: ☐ TMS Evaluation ☐ TDCS Evaluation ☐ Medication Referral	Diagnosis:
Relevant Medical, Psychiatric or Substance Abuse History:	
Additional Comments:	

Signature_____