Centre universitaire de santé McGill
McGill University Health Centre

MUHC - Neuromodulation Unit
1025 Pine Avenue West, P2.038
Montreal, QC H3A 1A1

Telephone: 514-934-1934 x 31881
Fax. : 514-843-1653

http://muhc.ca/neuromodulation
rtms@muhc.mcgill.ca

PATIENT REFERRAL

☐ rTMS Therapy

☐ Disease State(s): _____

Last/First Name of Patient	Name of Doctor
_____	_____
Address _____	Clinic _____
City _____ Prov _____	Address _____
Postal Code _____ Tel. ( ) _____	City _____ Prov _____
DOB YYYY/MM/DD Sex _____	Postal Code _____ Tel. ( ) _____
RAMQ _____ Exp _____	License _____ Fax. ( ) _____

PATIENT SCREENING INFORMATION

(In order to avoid time delays, please ensure the following questions have been completed with the patient.)

YES	NO	
☐	☐	1. Has the patient ever been a grinder, metal worker or welder?
☐	☐	2. Has the patient EVER had a metal foreign body in their eye?
☐	☐	If yes, please provide an orbital x-ray report prior to appt.
☐	☐	3. Is there a chance the patient may be pregnant? Indicate date of last menstrual period. _____.
☐	☐	4. Does the patient have any of the following:
☐	☐	Cardiac pacemaker
☐	☐	Aneurysm clip
☐	☐	Neurostimulator
☐	☐	Cochlear implants
☐	☐	Other implanted device(s) or metallic objects in body
☐	☐	5. Does the patient or any first degree relative have epilepsy?
☐	☐	6. Does the patient suffer from significant cardiac disease?
☐	☐	7. Is there any history of either alcohol or drug abuse?
☐	☐	8. Has the patient made any suicide attempts or is patient currently suicidal?
☐	☐	If yes, please indicate when and provide any notes available.
☐	☐	9. Does the patient have a criminal record?
☐	☐	10. Does the patient have any infectious diseases?
☐	☐	11. Does the patient have a personality disorder?
☐	☐	12. Has the patient ever had an MRI?

CLINICAL HISTORY: _____

_____

_____

_____

MEDICATION/DOSAGE: ☐ tricyclics ☐ Buproprion _____

_____

ALLERGIES: _____

Physician's Signature: _____ **Lic. #** _____ **Date:** _____