



## **PATIENT REFERRAL**

Assessment and possible rTMS therapy

Patient Name \_\_\_\_\_

Doctor Name \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Tel ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_

Email Report?  Yes \_\_\_\_\_

Birth Date \_\_\_\_\_ Sex \_\_\_\_\_  
mm/dd/yy

Fax Report?  Yes ( ) \_\_\_\_\_

## **PATIENT SCREENING INFORMATION**

*(To facilitate a timely referral process, please complete the following screening questions with the patient.)*

**YES NO**

1. Has the patient ever been a grinder, metal worker, or welder?
2. Has the patient EVER had a metallic foreign body in their eye?  
If yes, please provide an orbital x-ray report prior to appointment.
3. Is there a chance the patient may be pregnant? Date of last menstrual period \_\_\_\_\_
4. Does the patient have any of the following?
- Aneurysm clip
  - Cardiac pacemaker
  - Neurostimulator
  - Cochlear implants
  - Other implanted device(s) or metallic objects in body
5. Does the patient or any first degree relative have any kind of seizure disorder or epilepsy?
6. Does the patient suffer from significant cardiac disease?
7. Is there any history of either alcohol or drug abuse?
8. Do you consider the patient to be a significant suicide risk?
9. Is there a history of psychotic symptoms, now or in the past?

*If the patient has answered YES to any of these questions, the doctor's office should call BioLaser Therapy before submitting this referral form. Thank you.*

CLINICAL HISTORY AND DIAGNOSIS (including Axis II if present) \_\_\_\_\_

MEDICATION \_\_\_\_\_  tricyclics  SNRIs  SSRIs  MAOIs  Stimulants

Physician's signature \_\_\_\_\_ Date \_\_\_\_\_