Department of Psychiatry
Neuromodulation and Neuropsychiatry Unit
Rady Faculty of Health Sciences
University of Manitoba
PH: 204-237-2303 FX: 204-233-8051

Hôpital St-Boniface Hospital

rTMS Referral Form for Treatment Resistant Depression (please fax to 204-233-8051)

Referral Source:_____ Fax #:_____ Phone #:_____

Signature:_____ Date (DD/MMM/YYYY):_____

Patient's name:_____
Surname First Name Middle Name

Date of Birth (DD/MMM/YYYY):_____ Phone #:_____

Address:_____ City:_____ Postal Code:_____

MHSC#:_____ PHIN#:_____

Do any of the following apply to the patient: (If yes, please describe or attach additional information.)

Yes ☐ No ☐ Currently suffering from a major depressive episode according to the DSM V criteria
Yes ☐ No ☐ Failed to respond to two treatments with adequate dose and duration (treatment can include a course of psychotherapy)
Yes ☐ No ☐ Recent (within the last 12 months) normal serum B12 and TSH levels
Yes ☐ No ☐ Previous trial of rTMS
Yes ☐ No ☐ Previous trial of ECT (electroconvulsive therapy)
Yes ☐ No ☐ History of seizures in patient or 1st degree relative
Yes ☐ No ☐ Head injury or brain-related condition
Yes ☐ No ☐ Metal plate, implant, or fragment in the head
Yes ☐ No ☐ Current suicidal thoughts
Yes ☐ No ☐ Frequent or severe headaches
Yes ☐ No ☐ Currently taking Lorazepam 2mg or over; or equivalent dose
Yes ☐ No ☐ Substance use/abuse, including EtOH, cannabis
Yes ☐ No ☐ Pregnant or trying to become pregnant
Yes ☐ No ☐ Willing and able to participate in a daily treatment for up to 6 weeks
Yes ☐ No ☐ Voluntary and able to consent to treatment

*** Please attach a consult letter describing current medications including past trials and reasons for discontinuation. Also attach any other relevant reports or documents.**