DR KOBUS VAN DER WALT
Specialist General Psychiatrist

Patient Referral Form for Trans-Cranial Magnetic Stimulation (TMS)

Referring Professional's Information		Patient Information	
Name:		Name:	
Phone Number:		Phone Number:	
Email:		Email:	
HPCSA registration:		ID number:	
Practice number:		Medical aid details:	

Diagnosis			
Primary Diagnosis:		ICD10 code:	
Secondary Diagnosis:		ICD10 code:	
Current PHQ-9 (if relevant):			

	Please answer the following questions (Yes/No):	Y	N
1	Does the patient have a history of psychosis or catatonia?		
2	Does the patient have a history of mania?		
3	Does the patient have a history of substance and/or alcohol abuse?		
4	Does the patient have a history of seizures?		
5	Does the patient currently have suicidal thoughts?		
6	Has the patient ever attempted suicide?		
7	Is there a history of intolerable side effects on medication prescribed for the current episode?		
8	Does the patient meet the criteria for Treatment-Resistant Depression?		

	Medication History:	Dose	Date initiated	Date discontinued
1				
2				
3				
4				
5				

Referral-based TMS therapy service: Please indicate below the indication for TMS treatment protocol prescribed							
Treatment-resistant Depression		OCD		PTSD		Fibromyalgia	
Alzheimer's Dementia		Addiction & craving		Schizophrenia		Stroke rehab	
Other:							

Additional Information:	
Type, frequency, duration of psychotherapy:	
Previous neuromodulation interventions & response:	
Co-morbid and co-occurring conditions:	
Other relevant information or treatment requests:	

Doctor's signature:
Date:

Once completed, please submit this form to nursing@drkobusvanderwalt.co.za

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