MINDS

Mississauga Institute of Neurological Disorders and Stroke

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TRANSCRANIAL MAGENTIC STIMULATION REQUISITION FORM

PATIENT INFORMATION

Last Name:	First Name:	Gender: ☐ Male ☐ Female
Date of Birth (DD/MM/YYYY):	Home #:	Cell #:
Health Card #:	☐ Private Pay ☐ Motor Vehicle Accident ☐ Private Medical Insurance	

INDICATION(S) and Level of Evidence	rTMS protocol Requested	PAST MEDICAL HISTORY and Current Medications
☐ Depression (level A) ☐ mTBI/PCS depression (level A) ☐ Post-stroke rehabilitation upper extremity (Level A) ☐ Neuropathic Pain (Level A) ☐ Post stroke Aphasia (level B) ☐ Refractory tinnitus (level C)	☐ iTBS (Intermittent theta burst) ☐ HF rTMS (LDLPFC) +/- LF RDLPFC ☐ LF rTMS M1 contralesionally (Motor stroke) ☐ HF-rTMS of M1 contralateral to pain side (Neuropathic Pain) ☐ LF over right IFG (aphasia) ☐ LF rTMS Auditory Cortex (tinnitus) ☐ LF over right IFG (aphasia)	

SCREENING QUESTIONNAIRE	YES	NO
1. Has the patient ever had an adverse reaction to rTMS (repetitive transcranial magnetic stimulation)?		
2. Has the patient ever undergone an MRI for clinical purposes?		
3. Has the patient ever had an EEG?		
4. Has the patient ever had a convulsion/a seizure? If yes, please specify:		
5. Does anyone in the patient's family have epilepsy?		
6. Does the patient suffer from frequent and/or severe headaches?		
7. Has the patient ever had a severe head trauma or injury (including neurosurgery)? If yes, please specify:		
8. Has the patient ever had a stroke? If yes, please specify:		
9. Does the patient have any of the following implants in the body?		
a. (Metal) Plates and/or screws		
b. Vascular clips		
c. Artificial heart valve		
d. Metallic splinters/shrapnels/etc.		
e. Pacemaker		
f. Insulin pump		
g. Internal hearing aid (cochlear implant)		
h. Any other implant not listed; If yes, please specify:		
10. Is the patient pregnant, or is there a chance that they might be?		

REFERRING PHYSICIAN INFORMATION

Name and Billing number:	
Phone:	Fax: