Referral Form

Transcranial Magnetic Stimulation

St John of God Hospital

You may also refer electronically by searching "St John of God Hospital" on HealthLink or your GP practice management system such as Socrates or Healthone.
Please complete all sections fully and submit to:

Admissions Office, St John of God Hospital, Stillorgan, Co. Dublin, A94 FH92
Email: tmsreferrals@sjog.ie

Section 1: Patient Details

Full Name:

Date of Birth:

Gender: Male: ☐ Female: ☐ Other: ☐

Address:

Contact Number 1:

Contact Number 2:

Email:

Next of Kin: Name:

Next of Kin: Contact:

Referrer's Details

Name:

Address:

Contact Number:

Email:

Is this person related to you in any way? Yes ☐ No ☐

GP Details (if different from Referrer's)

Name:

Practice Address:

Contact Number:

Email:

Section 2: Reason for Referral

Reason for referal (tick all that apply):

- Persistent depressive symptoms despite adequate treatment trials ☐
- Seeking alternative to pharmacotherapy due to side effects ☐
- Contraindications or poor tolerance to antidepressants ☐
- Other (Specify):

Section 3: Primary Diagnosis

Primary Diagnosis:

- Major Depressive Disorder (MDD) ☐
- Treatment-Resistant Depression (TRD) ☐
- Other (Specify): ☐
- Duration of current episode:
- Current Medications:
- Any History of Psychotic Symptoms? Yes ☐ No ☐
- Any History of Suicidal Ideation/Attempts?
  - ☐ Yes (provide details)
  - ☐ No
- Current Mental State:

Section 4: Medical History

Primary Diagnosis:

Is there presence or history of:

- Metallic objects in the skull: Yes ☐ No ☐
- Electronic implants: Yes ☐ No ☐
- Intracranial hypertension: Yes ☐ No ☐
- Epilepsy: Yes ☐ No ☐
- Other significant medical history:

Declaration

I understand that I retain clinical responsibility for this patient until they are reviewed by a St John of God Hospital clinician.

- Signature:
- Date: