CENTRE FOR NEUROMODULATION

NHS
Northamptonshire Healthcare
NHS Foundation Trust

rTMS Referral Form

Please ensure all boxes are completed prior to submitting to enable us to offer an assessment date. Incomplete forms may be returned.

Date of referral:		
Referred by:		
Patient name:		
Patient DOB:		Age:
NHS no:		
Patient's GP and GP address / GP telephone no:		
NHFT patient (delete as appropriate)	Inpatient	Outpatient
Out of Area or Non NHFT (please delete as appropriate)	Out of Area	Non NHFT (Local NHS GP's etc)
Patient status on referral:		
Current Responsible Clinician:		
Referring Team contact details:		
Patient diagnosis on referral:		
Previous treatments:		
Current medication:		
Current therapies accessed:		

rTMS triage:-

Height/weight:

Hearing status:

Availability for treatment daily for 4 -6 weeks?

Consent for G.P. notes:

History of medication / Therapies accessed?

Increased contact with GP out of hours/additional medical services (COPD patients only):

Metal within the body, tattoos (head or neck), cochlear implants, titanium, pacemakers etc..

rTMS SCREENING FORM INCLUDED: Yes/No

UP TO DATE RISK ASSESSMENT INCLUDED: Yes/No

Brief Medical history (please continue on a separate page if required):

ACCESS TO HEALTH RECORDS REQUEST

G.P.
"I have been asked by the patient to act on his/ her behalf, both the patient and myself have signed the authorisation to confirm this

Signed: _____ Date: ____/____/_____

PATIENT
"I declare I am the applicant and information given on this form is correct to the best of my knowledge. I request access to the aforementioned health records, as is my entitlement under the terms of current Data Protection legislation".
I acknowledge that the Trust may take further steps to confirm my identity.
I confirm that I have authorised the applicant to apply for my records on my behalf "

Signed: _____ Date: ____/____/_____

Patient /Service User Signature Authorisation:

For the Centre for Neuromodulation use:		
Date added to database/SystmOne:		
Date discussed by team:		
Appointment arranged for:		
Date placed on waiting list:		
Treatment start date arranged:		
Discharge summary sent to GP and referring team:		
Funding required: Email sent to contracting regarding funding:	YES	NO