Referral Form for rTMS Treatment

Referrer's Name:

Are you a: GP NHS Psychiatrist Private Psychiatrist Occupational Health Professional

Referrer's Email:

Referrer's Telephone Number:

Referrer's Practice Address:

Condition Referring For: Depression OCD Other

Patient Name:

Date of Birth:

Patient Email:

Patient Telephone Number:

Patient address:

Payor: Self-Funding Insurance*

**(Most private medical insures are reviewing applications to fund on a case by case basis)*

Patient's Brief Medical History:

Previous Treatments (Including Medication)

To finalise the referral or for further information, please contact our rTMS practitioner,
rtms@nightingalehospital.co.uk
+44 (0)20 7535 7700