Dr. A. Kaleel, MD, MSc.
Vascular Neurology/Stroke (Yale/ABPN) • EMG/Electrodiagnostic Medicine (ABEM)
Headache Management (dual AQH/UCNS) • Behavioral Neurology & Neuropsychiatry (UCNS)
Interventional Pain/Pain Medicine (ABPM) • Sports Neurology • Hyperbaric Medicine (M.Sc)
Assistant Clinical Professor- Medicine, McMaster University

CONSULTATION FOR TRANSCRANIAL MAGNETIC STIMULATION (TMS)

Please fax completed forms to (226)-647-1010 or complete on Ocean

Patient Name: ________________________________ **Birth Date:** ______________________ **(YYYY/MM/DD)**

Health Card Number: ____________________________ **Gender:** ☐ **M** ☐ **F**

Address: ____

Home Phone: ____________________________ **Work Phone:** ____________________________

Referring Physician: ____________________________ **Billing Number** ______________________

PATIENT SCREENING INFORMATION (Please complete as thoroughly as possible) :

1. Has the patient had a metallic foreign body in their eye? ☐ Yes ☐ No
2. Does the patient have any of the following:
   a) Cardiac pacemaker or implanted defibrillator? ☐ Yes ☐ No
   b) Cochlear Implants? ☐ Yes ☐ No
   c) Neurostimulator? ☐ Yes ☐ No
   d) Medication Infusion device? ☐ Yes ☐ No
   e) Any other implanted device or metal object in their head/neck/chest? ☐ Yes ☐ No
3. Does the patient have a history of seizures? ☐ Yes ☐ No
4. Is there a chance that the patient could be pregnant? If so, date of LMP ☐ Yes ☐ No

*HeadworX to obtain an EEG prior to treatment, if indicated ☑ Yes ☐ No, reason: ________________

CLINICAL HISTORY/DIAGNOSES (attach, if necessary)

____
____
____
____
____
____

Patient has been informed that TMS is NOT covered by OHIP i.e. the fee for treatment is the responsibility of the patient, and that the patient otherwise remains under the care of their referring physician ☐ Yes ☐ No

This does not constitute a general neurology consult- a separate referral should be made for other indications.

Date: ______________ Signature: ______________

Thank you for providing this information. **PLEASE FAX REFERRAL TO: (226) 647-1010**
If you have any questions, please contact **HeadworX at (519) 208-9991**

475 Park Street, Suite 201 • Kitchener, Ontario • N2G 4V5

Phone: (519) 208-9991 | Fax: (226) 647-1010 |email: reception@headworxclinic.com | website: headworxclinic.com