

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: <input type="checkbox"/> M <input type="checkbox"/> F
Address: _____	
Home Phone: _____	Work Phone: _____
Referring Physician: _____	Billing Number _____

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

- Has the patient had a metallic foreign body in their eye? Yes No
- Does the patient have any of the following:
 - Cardiac pacemaker or implanted defibrillator? Yes No
 - Cochlear Implants? Yes No
 - Neurostimulator? Yes No
 - Medication Infusion device? Yes No
 - Any other implanted device or metal object in their head/neck/chest? Yes No
- Does the patient have a history of seizures? Yes No
- 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



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