**tTMS Referral Form**

If you are applying as a private patient, please contact your GP and ask for details of your mental health history, including any correspondence from your psychiatrist, to be sent to us with this form. Alternatively, your GP or mental health professional may complete the form and information on your behalf. Please email to [info@tranquality.com](mailto:info@tranquality.com). All potential patients receive a comprehensive assessment in person, to assess suitability, to ensure therapies are delivered safely and that no contraindications exist which may prevent treatment being carried out. If you have any questions about completing this document, please contact [info@tranquality.com](mailto:info@tranquality.com)

|  |  |
| --- | --- |
| Name |  |
| Date of Birth |  |
| Address |  |
| County |  |
| Postcode |  |
| Phone Number |  |
| Mobile |  |
| Email |  |
| Preferred Contact Method |  |
| Preferred Contact Time |  |
| Name & Address of GP |  |
| Who is referring? (e.g. Self-referral, mental health professional, GP) |  |
| Referrers’ Contact Details (if different from above) |  |
| NHS Number (if known) |  |
| Reason for Treatment Request |  |

To help us provide you with the best care possible, it is important that we are aware of any current or previous medical conditions. This allows us to ensure our clinicians can give you the most appropriate guidance. Please mark ‘X’ if you currently or have previously suffered from any of the below.

Alcohol abuse

Substance abuse

Personality Disorder

Epilepsy

Please tick this box if you do not wish to declare medical information on this form

Please tick this box to confirm you are happy for TranQuality Solutions Ltd. to communicate with you using the details you have provided on this form.

**\*Signature of referrer:**

**Date:** Click here to select the date

\*Please note, if this form is emailed this will be accepted as signature.