

**Instructions**

Complete this form to request repetitive transcranial magnetic stimulation (rTMS) for a TAC client needing:

* acute treatment in an outpatient setting,
* maintenance treatment in an outpatient setting, or
* treatment in an inpatient setting

# SectioN 1

## TAC Client details

|  |  |
| --- | --- |
| Client first name |  |

|  |  |
| --- | --- |
| Client last name |  |

|  |  |  |  |
| --- | --- | --- | --- |
| TAC claim number |  | Date of accident | / / |

|  |  |  |  |
| --- | --- | --- | --- |
| Date of birth | / / |  |  |

|  |  |
| --- | --- |
| Street name and number |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Suburb/Town |  | Post code |  |

# Section 2

## PROVIDER details

### rTMS provider

|  |  |
| --- | --- |
| rTMS provider name |  |

|  |  |
| --- | --- |
| Street name and number |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Suburb/Town |  | Post code |  |

|  |  |
| --- | --- |
| Provider phone number |  |

|  |  |
| --- | --- |
| Provider email address |  |

### Referring psychiatrist

|  |  |
| --- | --- |
| Name of treating psychiatrist |  |

(referrer)

|  |  |
| --- | --- |
| Street name and number |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Suburb/Town |  | Post code |  |

Please provide at least one phone number

|  |  |
| --- | --- |
| Mobile phone number |  |

|  |  |
| --- | --- |
| Business phone number |  |

|  |  |
| --- | --- |
| Provider email address |  |

# Section 3

## ELIGIBILITY CRITERIA

The TAC aligns with the Medicare Benefits Schedule Eligibility Criteria when considering a request for rTMS treatment. Please indicate below if your patient meets the criteria.

|  |  |
| --- | --- |
| 1. Is the patient >18 years of age and been diagnosed with a major depressive episode? |  |

|  |  |
| --- | --- |
| 1. Has the patient undertaken adequate trials of at least two different classes of antidepressant medication, unless contraindicated? (If contraindicated, please comment below at Section 4) |  |

|  |  |
| --- | --- |
| 1. Has the patient undertaken psychological therapy unless inappropriate? |  |

|  |  |
| --- | --- |
| 1. Has the patient previously received rTMS treatment? |  |

# Section 4

## TREATMENTS TRIALLED

### Current medication

|  |  |  |
| --- | --- | --- |
| Medication name | Dose | Commencement date |
|  |  | / / |
|  |  | / / |
|  |  | / / |
|  |  | / / |

### Previously prescribed medication

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Medication name | Class | Dose  (range) | Duration  (weeks) | Adherence | Year/s trialled | Reason for cessation |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

### Psychological therapy

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Therapy type | Frequency | Number of sessions | Year/s provided | Outcome |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

### Details of previous rTMS treatment (if applicable)

|  |  |  |  |
| --- | --- | --- | --- |
| Dates  (month/year) | Type  (acute/maintenance) | Number of sessions | Outcomes/response |
| / |  |  |  |
| / |  |  |  |

# Section 5

## TREATMENT REQUEST TYPE

Please indicate which type of treatment you are requesting.

|  |  |  |
| --- | --- | --- |
| Acute treatment in an outpatient setting? |  |  |

**If yes**, complete sections **6 and 9**

|  |  |  |
| --- | --- | --- |
| Maintenance treatment in an outpatient setting? |  |  |

**If yes**, complete sections **7 and 9**

|  |  |  |
| --- | --- | --- |
| Treatment in an inpatient setting? |  |  |

**If yes**, complete sections **8 and 9**

# Section 6

## CLINICAL INDICATION AND DETAILS OF OUTPATIENT ACUTE TREATMENT REQUEST

Please provide clinical indication for requested **acute** rTMS treatment.

|  |
| --- |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| Commencement date | / / | Anticipated number of **acute** treatments |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Frequency |  |  |  |

Please provide how this request for treatment is related to the transport accident.

|  |
| --- |
|  |

### Outcome measures

The TAC requires outcome measures to be collected for all rTMS treatment.

|  |  |
| --- | --- |
| I confirm that patient outcomes will be measured using the Hamilton Depression Rating Scale (HDRS)  at baseline, post 15th session, completion of treatment and 1 month post treatment. |  |

|  |  |
| --- | --- |
| I confirm that the patient will be requested to complete the World Health Organisation Depression, Anxiety and Stress Scale (WHO DAS 2.0) at baseline, post 15th session, completion of treatment, and 1 month  post treatment. |  |

Any future requests for maintenance treatment will require submission of these outcome measures for review by the TAC Clinical Panel.

# Section 7

## CLINICAL INDICATION AND DETAILS OF OUTPATIENT MAINTENANCE TREATMENT REQUEST

Please provide clinical indication for requested Maintenance rTMS treatment.

(Patient must have completed an acute treatment course prior to commencing maintenance sessions. All requests for maintenance treatment will be reviewed by the TAC Clinical Panel)

|  |
| --- |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| Commencement date | / / | Anticipated number of **maintenance** treatments |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Frequency |  |  |  |

Please provide the outcome measures from the acute treatment and attach completed rating scales.

|  |
| --- |
|  |

### Outcome Measures

The TAC requires outcome measures to be collected for all rTMS treatment, including for maintenance treatment.

# Section 8

## PATIENT REQUIRES INPATIENT rTMS TREATMENT

### ONLY COMPLETE THIS SECTION IF YOU ARE REQUESTING INPATIENT rTMS

rTMS is typically delivered in an outpatient care setting, and only provided in an inpatient care setting in exceptional circumstances. Please provide in the responses below why it is necessary for the patient to receive treatment as an inpatient. All requests for inpatient rTMS treatment will require review by the TAC Clinical Panel. A member of the Clinical Panel may be in contact with you to discuss this further and consider other alternatives if appropriate.

|  |  |
| --- | --- |
| I confirm that the patient is required to be admitted to a psychiatric hospital as an inpatient for rTMS treatment, the treating psychiatrist has undertaken a mental health assessment and a rationale is  provided below. |  |

### Clinical indication for admission to inpatient psychiatric hospital for delivery of rTMS treatment

|  |  |
| --- | --- |
| High risk of harm to self, or others (If so please clarify why rTMS is the treatment of choice at this time) |  |

|  |  |
| --- | --- |
| Incapacitating symptoms or distress |  |

|  |  |
| --- | --- |
| Significant problems in initiating treatment, or continuing treatment, in an outpatient setting. |  |

**If yes**, please provide details.

|  |
| --- |
|  |

|  |  |
| --- | --- |
| Other |  |

**If yes**, please provide details.

|  |
| --- |
|  |

Please provide clinical indication for requested inpatient rTMS treatment.

|  |
| --- |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| Commencement date | / / | Anticipated number of treatments |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Frequency |  | Anticipated duration of admission |  |

Please describe how this request for treatment is related to the transport accident.

|  |
| --- |
|  |

### Outcome Measures

The TAC requires outcome measures to be collected for all rTMS treatment.

|  |  |
| --- | --- |
| I confirm that patient outcomes will be measured using the Hamilton Depression Rating Scale (HDRS) at baseline, post 15th session, completion of treatment and 1 month post treatment. |  |

|  |  |
| --- | --- |
| I confirm that the patient will be requested to complete the World Health Organisation Depression, Anxiety and Stress Scale (WHO DAS 2.0) at baseline, post 15th session, completion of treatment, and 1 month  post treatment. |  |

Any future requests for maintenance treatment will require submission of these outcome measures for review by the TAC Clinical Panel.

Please attach any additional information you deem relevant to this request.

# Section 9

## CONFIRMATION BY TREATING (REFERRING) PSYCHIATRIST

|  |  |
| --- | --- |
| I certify that all the information contained in this request form is true and correct according to my records  and professional assessment. |  |

|  |  |
| --- | --- |
| Treating psychiatrist name |  |

|  |  |
| --- | --- |
| Signature  Insert image (jpg/png) of signature.  (Or print, sign and scan the form) | Shape  Description automatically generated with low confidence |

Icon

Description automatically generated

|  |  |
| --- | --- |
| Date | / / |

Icon

Description automatically generated

**Submitting this form**

Email your completed form to your TAC claims manager or to [info@tac.vic.gov.au](mailto:info@tac.vic.gov.au) with the client’s TAC claim number in the subject line. Please also attach any supporting documentation.

**Privacy**

The TAC will retain the information provided and may use or disclose it to make further inquiries to assist in the ongoing management of the claim or any claim for common law damages. The TAC may also be required by law   
to disclose this information. Without this information, the TAC may be unable to determine entitlements or assess whether the treatment is reasonable and may not be able to approve further benefits and treatment. If you require further information about our privacy policy, please call the TAC on 1300 654 329 or visit our website at [www.tac.vic.gov.au](http://www.tac.vic.gov.au)

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