Repetitive Transcranial Magnetic Stimulation (rTMS) Referral Form

Patient Contact Information

NAME: Last ________________________________ First ____

PHN: _________________ DOB: ______________ Gender _____________________ Phone: ______________________

Address: ____ City: __________________ Postal code________________

E-mail: ____

Next of Kin: ____________________ Relationship to Patient _______________ Phone: _________________________

Referring Practitioner

Name: ____________________________________ MSP BILLING NUMBER ____________________________________

Office Address ______________________________ City: ______________________ Postal Code: ____________

Office Fax: ________________________________ Office Phone: ____

Medical Information

Reason for Referral : ____

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Attach collateral information such as EMR notes, previous consults, and hospital discharge summaries.

Aggressive Behaviour: YES NO

If yes, please describe behavior(s) and whether it is current or past behavior: _______________________

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Suicidal Behaviour: YES NO

If yes, please describe behavior(s) and whether it is current or past behavior: _______________________

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Medications (if any): ____

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PLEASE FAX to 604-873-3095