MOOD DISORDERS ASSOCIATION OF BRITISH COLUMBIA

A BRANCH OF Lookout Housing + Health Society

# 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 :** _____

_____

_____

**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:** _____

_____

**Suicidal Behaviour: YES NO**

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

_____

**Medications (if any):** _____

_____

**PLEASE FAX to 866-821-5992**