Brainstim Calgary Referral Form

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Patient Demographic Information

Patient Full Name: _____ **Gender:** ____ **Date of Birth:** ____ / ____ / ____ (DD/MM/YYYY)

PHN/AHS: _____ **Email:** _____

Address: _____ **Home Phone:** _____ **Mobile Phone:** _____

Referring Provider Information

Specialty: ☐ Psychiatrist ☐ GP /Family Physician/ Nurse Practitioner ☐ Other _____ _____

Date of Referral: _____

Name: _____ **Billing #:** _____ **Signature:** _____

Clinic Name: _____**Address:** _____

Phone: _____ **Fax:**_____

Referral Details

Assessment of *diagnosis and suitability* for the Program or Programs of Interest

☐ **TMS (Transcranial Magnetic Stimulation)** ☐ **Ketamine Treatment**

Main Concerns to Treat

- ☐ Depression
- ☐ Anxiety
- ☐ SAD (Seasonal Affective Disorder)
- ☐ Other (Specify):_____
- ☐ Obsessive-Compulsive Disorder (OCD)
- ☐ Chronic Pain
- ☐ Post-Traumatic Stress Disorder (PTSD)
- ☐ Substance use disorder : Alcohol, cannabis, stimulant.

Additional details for the Referral (Please attach a referral letter with relevant Medical History, Psychiatric History, Risk History, Substance Use, Current Medication list, and Past Psychiatric Medication trials if applicable)

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Thank You for Your Referral.

BrainStim is proud to provide innovative and evidence-based interventions for those living with mental health conditions to achieve the best outcomes.