



Referral Form

Patient Information:

First Name: _____ Last Name: _____

DOB: _____ PHN: _____ Phone: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Physician Information:

Referring Physician: _____ Family Doctor: _____

Outpatient Psychiatrist (If Applicable): _____

Referring for:

- IV or IN Ketamine rTMS Ketamine Assisted Psychotherapy
- SAP Application for Psilocybin

Reason for referral:

Please acknowledge the following:

- The patient has been informed that there is a cost for ketamine therapy and SAP applications. Current pricing can be obtained by visiting thelinden.ca, or by contacting our office.

Per: _____ Date of Referral: _____