THE LINDEN
MEDICAL CENTRE

241-1288 Central Avenue
Prince Albert, SK,
S6V 4V8

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rTMS Referral Form
Prince Albert

Patient Information:

First Name: _____ Last Name: _____

DOB: _____PHN: _____ Phone: _____

Address: _____

City: _____ Province: _____Postal Code: _____

Physician Information:

Referring Physician: _____ Phone: _____

Family Doctor: _____Outpatient Psychiatrist (If Applicable): _____

Reason for Referral/Patient History:

_____

_____

_____

Medications:

_____

_____

_____

NOTE:

rTMS is most effective for patients who have treatment resistant depression (2 or more failed treatments) but can be safely used in patients with co-morbid anxiety or a bipolar disorder in a depressive phase. **Active psychosis, mania or substance abuse are contraindicated.**

Per: _____ Date of Referral: _____