THE LINDEN
MEDICAL CENTRE

200-149 Pacific Avenue
Saskatoon, SK,
S7K 1N8

Phone: 306-700-5160
Fax: 306-700-5161
Email: office@lindenhealth.ca

Referral Form

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): _____

Referring for:

- ☐ IV Ketamine
- ☐ rTMS (Repetitive Transcranial Magnetic Stimulation)
- ☐ SAP Application for Psilocybin/MDMA

Reason of 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: _____