THE LINDEN HEALTH CENTRE

#702-11010 101 St NW,
Edmonton, AB,
T5H 2T1

Phone: 825-601-5014
Fax: 833-664-7276
Email: Edmonton@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)

Reason of Referral:

Please acknowledge the following:

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

Per: _____ Date of Referral: _____