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## Referral Form - Edmonton

### 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 rTMS treatments and ketamine therapy.  
Current pricing can be obtained by visiting [thelinden.ca](http://thelinden.ca), or by contacting our office.

Per: \_\_\_\_\_ Date of Referral: \_\_\_\_\_