MOOD DISORDERS ASSOCIATION OF BRITISH COLUMBIA

A BRANCH OF Lookout Housing + Health Society

Repetitive Transcranial Magnetic Stimulation (rTMS) - Referral Form

Referring physician information

Name:

MSP Number:

Office Address:

Office Phone:

Office Fax:

Patient information

First Name:

Last Name:

MSP:

Date of Birth:

Sex:

Phone:

Email:

Address

Medical information

Reason for referral: (Attach collateral information such as EMR notes, previous consults, and hospital discharge summaries)

Aggressive Behaviour: YES ☐ NO ☐ If yes, please describe behavior(s) and whether it is current or past behavior:

Suicidal Behaviour: YES ☐ NO ☐ If yes, please describe behavior(s) and whether it is current or past behavior:

Current Medications (if any):

PLEASE FAX COMPLETED FORM AND ANY ATTACHMENTS

TO MDABC at 1-866-821-5992