NeuroLinks
Neuropsychiatric Centre

Referral Form

* Required fields

Patient information

Full Name: * _____ (Last) _____ (First)

Address: _____

_____

Phone: * _____

PHN: * _____

Referring Doctor

Referrer Name: * _____

MSP#: * _____

Phone: _____

Medical history

Diagnosis(es) *

- ☐ Major depressive disorder
- ☐ Bipolar disorder
- ☐ Psychotic illness
- ☐ Obsessive-compulsive disorder
- ☐ Anxiety disorder
- ☐ Substance/alcohol misuse
- ☐ Other (please give a brief description in the comment box)

Treatment Options *

- ☐ Transcranial Magnetic Stimulation
- ☐ To be determined in collaboration with the patient
- ☐ Ketamine

Potential contradindications for ketamine

- ☐ Pregnancy
- ☐ History of psychosis
- ☐ Unstable angina
- ☐ Uncontrolled hypertension
- ☐ Uncontrolled hyperthyroidism
- ☐ Severe liver disease
- ☐ Elevated intracranial/intraocular pressure

Potential contradindications for TMS

- ☐ Aneurysm clips
- ☐ Stent in the neck or brain
- ☐ Deep brain stimulator
- ☐ Metal devices or objects implanted in or near the head

Referrer Signature: _____ Date: _____

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If you have further questions, you are most welcome to contact NeuroLinks.