OPTIMIND TMS Treatment Centres

Email: connect@myoptimind.ca
Fax: 778.652.3974

PHYSICIAN REFERRAL FORM

PATIENT INFORMATION	
Name of Patient:	Address:
DOB:	Phone:
Client # (VAC, RCMP, WORKSAFE BC, PHN)	Email:

REFERRING DOCTOR	PRESENTING PROBLEM
Referrer name:	(Please attach separate leader or psychiatric assessments, if available)
Email:	
Fax:	

MEDICAL HISTORY

Diagnosis(es)

☐ Major depressive disorder
☐ Anxiety Disorder Bipolar
☐ Obsessive compulsive disorder
☐ post-traumatic stress disorder
☐ disorder
☐ Substance use disorder
☐ Others (please specify below)

Brief Description of Illness (if diagnosis not included above)

Current Medication List:	Past Psychiatric Medication trials:
Drug Allergies:	Additional Information: