NeuroLinks
Neuropsychiatric Centre

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

Referrer Signature: _____ Date:_____

Watch this video for more information about TMS

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