Phone:**1.866.999.STIM (7846)** | Fax:**1.833.999.STIM (7846)** | Info@brainstim.ca | www.Brainstim.ca

Halifax: #201, 998 Parkland Dr, Halifax,NS B3M 0A6

BrainStim Health Referral Form – Nova Scotia

Patient Demographic Information

Patient Full Name: _____ **Date of Birth:** ____ / ____ / ____ (DD/MM/YYYY)

MSI: _____ **Gender:** ☐ Male ☐ Female ☐ Other: _____ **Pronouns:** _____

Public Service Status: ☐ Veteran K # _____ ☐ RCMP Hermis R #_____ ☐ First Responders ☐ Police Service

Address: _____ **Home Phone:** _____ **Mobile Phone:** _____

Email: _____

Referring Provider Information

Specialty: ☐ Psychiatrist ☐ GP /Family Physician ☐ Nurse Practitioner

Name: _____ **Billing #:** _____ **Signature:** _____

Clinic Name: _____**Address:** _____

Phone: _____ **Fax:**_____ **Date of Referral:** _____

Referral Details

Assessment of *diagnosis and suitability* for the Program or Programs of Interest

☐ TMS (Transcranial Magnetic Stimulation)

☐ Ketamine Assisted Psychotherapy (KAP)

Main Concerns to Treat

☐ Depression
☐ Anxiety
☐ Chronic Pain
☐ Obsessive-Compulsive Disorder (OCD)
☐ Post-Traumatic Stress Disorder (PTSD)
☐ Other (Specify):_____

Additional details for the Referral (Please attach a referral letter with relevant Medical History, Psychiatric History, Risk History, Substance Use, Current Medication list, and Past Psychiatric Medication trials if applicable)

_____

_____

_____

_____

_____

_____

Thank You for your referral.