Phone: **604.416.0115** | Fax: **604.428.6110** | Info@brainstim.ca | www.Brainstim.ca

Vancouver: First Floor, 1622 West 7th Avenue, Vancouver, BC | **South Surrey:** 307 – 3211 152nd Street, Surrey, BC

Surrey: 10626 City Pkwy, Surrey, BC

BrainStim Health Referral Form – Western Canada

Patient Demographic Information

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

PHN/AHS: _____ **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

Please indicate the Physician and Location you'd like to send the Referral to

☐ Vancouver - Dr. Alexander Leung

☐ Surrey - Dr. Venugopal Karapareddy

☐ South Surrey - Dr. Kiran Sayyaparaju

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.

BrainStim is proud to provide innovative and evidence-based interventions for those living with mental health conditions to achieve the best outcomes.