Repetitive Transcranial Magnetic Stimulation Clinic
Vancouver General Hospital, 6th floor Willow Pavilion
805 West 12th Avenue
Vancouver, BC V5Z 1M9
Tel: (604) 875-4111 local 64096 Fax: (604) 675-2464
http://psychiatry.vch.ca/tms.htm

Referral Form

NAME OF PATIENT	DATE OF BIRTH	MARITAL STATUS
PHN	DATE OF REFERRAL	GENDER M / F
ADDRESS	PHONE (H) (Cell) (W)	
REFERRING PHYSICIAN NAME Discipline: FP / Psychiatrist / other PHONE	MSP # FAX	
PRESENTING PROBLEM (please attach separate letter or psychiatric assessments, if available)		
PSYCHIATRIC HISTORY FAILED ECT COURSES yes / no SUICIDAL IDEATION yes / no	SUBSTANCE USE	
MEDICAL ISSUES: (headaches, tinnitus, cardiovascular conditions, implanted metallic objects, pacemaker, and seizures)		
CURRENT MEDICATION LIST DRUG ALLERGIES	PAST PSYCHIATRIC MEDICATION TRIALS	
EMPLOYMENT yes / no	DISABILITY yes / no	
ADDITIONAL INFORMATION		