VERIDIAN WELLNESS CLINICS
Repetitive Transcranial Magnetic Stimulation (rTMS) Referral Form

PATIENT INFORMATION

First Name: _____

Last Name: _____

Date of Birth (mm/dd/yyyy): _____

Personal Health Number (PHN): _____

Province of PHN (Quebec PHN note accepted): _____

Sex: _____

Phone number: _____

Address (Street address, city, province, postal code):

_____

Email (Mandatory): _____

WorkSafeBC claim number (or N/A): _____

REFERRING PHYSICIAN INFORMATION

Name of referring physician: _____

BC MSP#: _____

Phone number: _____

Fax number: _____

Address: _____

Referrals with insufficient information will be sent back for correction

REASON FOR REFERRAL

☐ Repetitive Transcranial Magnetic Stimulation (rTMS)

- rTMS can be a very effective treatment for treatment-resistant depression (both MDD and bipolar depression)
- other diagnoses rTMS can be helpful for include PTSD, anxiety

* Please note that rTMS is not covered by BC MSP and patients are responsible for the associated fees. Patients may be able to seek cost recovery through health benefit accounts

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Narrative description of reason for referral (legibly handwritten or separately attached type notes OK):

_____

_____

_____

_____

PLEASE CHECK THE FOLLOWING TO ACKNOLWEDGE:

☐ The referring physician agrees to remain as MRP

☐ The patient has been informed that the cost of rTMS service and any services not covered by BC MSP/Provincial Health Insurances is the responsibility of the patient

☐ The patient has been informed of missed appointment fee policy of the Veridian Wellness Clinics (refer to https://www.veridianwellnessclinics.com/), and aware that the rate of the missed appointment fees are subject to change without notice

☐ referring physician/NP agrees not to make referrals with the following elements: child & adolescents aged 19 and under), patients with major cognitive impairments, patients with psychosis, patients with complex care needs, patients with primary complaints in the areas of neurodevelopmental disorder such as autism or learning disabilities (except ADHD), sexual medicine, history of significant head trauma, MCFD involvements, patients with on-going legal litigations/involvements, patients of no-fixed address, patients with primary personal disorders, patients with history of physical and verbal violence & aggressions

Referring physician signature: _____

Date of Referral: _____

Please fax all consultation requests to: 6042275471