BrainStim Healthcare

First Floor, 1622 West 7th Avenue, Vancouver, BC, V6J 1S5

Main line: 604 416-0115 Fax: 604 428-6110

http://brainstim.ca

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 specialist assessments, if available)		
PSYCHIATRIC HISTORY FAILED ECT COURSES yes / no SUICIDAL IDEATION yes / no	SUBSTANCE USE	
PAIN HISTORY and MEDICAL ISSUES: (include cardiovascular conditions, implanted metallic objects, pacemaker, and seizures)		
CURRENT MEDICATION LIST DRUG ALLERGIES	PAST PSYCHIATRIC AND/OR PAIN MEDICATION TRIALS	
EMPLOYMENT yes / no	DISABILITY yes / no	
ADDITIONAL INFORMATION		