Clinic: 604.416.0115

Fax: 604.428.6110

Email: **info@brainstim.ca**

#307 – 3211 C 152nd Street, Surrey, BC V3S 3M1

Website: https://brainstim.ca

Physician Referral

NAME OF PATIENT	DATE OF BIRTH	MARITAL STATUS
PHN	**DATE OF REFERRAL**	**GENDER M / F**
ADDRESS	**CONTACT NUMBERS** **CELL:** **WORK:**	
REFERRING PHYSICIAN NAME: Discipline: FP / Psychiatrist / Other MSP # PHONE FAX		
PRESENTING PROBLEM (please attach separate letter or specialist assessments, if available)		
PSYCHIATRIC HISTORY: **FAILED ECT COURSES: Y / N** **SUICIDAL IDEATION: Y / N**	**SUBSTANCE USE:**	
PAIN HISTORY and MEDICAL ISSUES: (include cardiovascular conditions, implanted metallic objects, pacemaker, seizures)		

CURRENT MEDICATION LIST: **DRUG ALLERGIES:**	**PAST PSYCHIATRIC AND/OR PAIN MEDICATION TRIALS:**
EMPLOYMENT: Y / N	**DISABILITY: Y / N**
TYPE OF EMPLOYMENT:	
ADDITIONAL INFORMATION:	