RECONNECT
MENTAL HEALTH

Reconnect Mental Health
Phone: 1-403-527-8468
Fax: 1-587-824-2606
Website: reconnectmentalhealth.com

Patient Name: _____ **Date of Birth:** _____

PHN: _____ **Practitioner:** _____

Address: _____ **PRACID:** _____

Phone: _____ **Phone #:** _____

Email: _____ **Fax #:** _____

****PATIENT EMAIL ADDRESS IS REQUIRED****
or will automatically be declined

Repetitive Transcranial Magnetic Stimulation (rTMS) Referral Form

Patient Eligibility (must meet all criteria)**:**

- ☐ Age 18+
- ☐ Diagnosis of major depressive disorder, post-traumatic stress disorder, obsessive-compulsive disorder, generalized anxiety disorder or depression secondary to traumatic brain injury/ concussion
- ☐ Not actively suicidal (requires higher level of care)
- ☐ No non-removable metallic hardware or devices in the head region (cochlear implants, deep brain
- ☐ stimulators, foreign metal fragments, etc.) - dental hardware is acceptable
  No prior history of epilepsy
- ☐ Depression and anxiety symptoms not deemed primarily caused by substance use
- ☐ No history of violence/ physical assault towards others
- ☐ No severe active substance use issues

Referral must include **both** of the following to be processed:

- ☐ recent clinical note pertaining to the reason for referral
- ☐ previous psychiatric consult notes (if available)
  - ☐ (if applicable) patient is under the care of psychiatrist Dr._____

Clinical background (personality traits, suicidality, diagnosis, comorbidities, patient goals):

_____

_____

_____

_____

_____

Referring physician agrees to continue their care once patient has completed treatment at Reconnect Mental Health

Primary Care Provider Signature: _____ Date: _____