PATIENTS REFERRAL

Elumind Centres for Brain Excellence

Please note that this is a one-time consultation only.

Please **FAX** completed referral form to: **604-243-0486** or send via **EMR**

elumind

PATIENT INFORMATION

Full Legal Name: _____ Referring Doctor's Name: _____

Phone Number: _____ Referring Doctor's Phone Number: _____

Date of Birth: _____

Brief synopsis of psychological - psychiatric history:

SECTIONS BELOW TO BE FILLED BY REFERRING PHYSICIAN/ MOA

PATIENT INFORMATION

Patient Full Name: _____ Personal Health Number (PHN): _____

Referring Doctor Full Name: _____ Dr's Billing Number: _____

Date of Referral: _____ Dr's Phone Number: _____

Reason of Referral:

DIAGNOSIS HISTORY

- ☐ ADHD
- ☐ Anxiety Disorder
- ☐ Autism Spectrum Disorder
- ☐ Bipolar Disorder
- ☐ Depressive Disorder
- ☐ Eating Disorder
- ☐ Obsessive Compulsive Disorder
- ☐ Post-Traumatic Stress Disorder
- ☐ Psychotic Disorder
- ☐ Substance Use Disorder
- ☐ Other, Please specify: _____

HISTORY OF MEDICATION

Medication	Dosage	Start Date	End Date	Effective	Side Effects

CONSULTATION NOTES

Please attach any consultation note from Psychiatrist, Psychologist, or Neurologist:

The sole objective of our assessment is to facilitate the potential diagnosis required for advanced brain health technology treatments (TMS, PBM, Neurofeedback, etc). During this assessment, we will formulate personalized treatment recommendations based on the assessment outcomes. Kindly submit consultation notes/ documents for thorough consideration.