Bloom rTMS Clinic
628 12 Ave SW
Calgary, AB T2R 0H6
Tel: 825-305-1042 Fax: 825-252-5554
contact@bloomrtms.com

Referral Form for Repetitive Transcranial Magnetic Stimulation

INFORMATION FOR REFERRING PROVIDERS	PLEASE NOTE THE FOLLOWING CRITERIA
▪ A family physician or psychiatrist referral is recommended ▪ The referring physician must provide concurrent care during the time limited treatment offered within the Neurostimulation Clinic ▪ Please ensure that your patient consents to the referral being made ▪ This referral form is for Bloom rTMS only ▪ Fax the completed referral form to 825-252-5554	▪ rTMS is not suitable for clients who have a history of epilepsy or other seizure disorders ▪ rTMS may not be suitable for clients who have metal or implanted medical devices ▪ Clients must have the capacity to attend daily sessions at our downtown Calgary clinic, located in the Beltline area ▪ Clients must have a diagnosis of any of the following: Depression, OCD, Anxiety, PTSD, Substance Use Disorder, Chronic Pain, Tinnitus, Mild Cognitive Impairment

INFORMATION FOR THE PATIENT BEING REFERRED

What is rTMS?
Repetitive Transcranial Magnetic Stimulation (rTMS) is a non-invasive and well-tolerated form of brain stimulation. rTMS has been approved by Health Canada for the treatment of depression in adults. rTMS is also effective in treating mood disorders, pain, substance use disorders and neurological disorders.

How Does it Work?
The treatment involves applying a series of short magnetic pulses to brain regions affected, which stimulate brain cells in the targeted areas in order to restore healthy activity patterns.

Who Can Benefit from rTMS?
rTMS treats several psychiatric conditions, such as Depression, OCD, Anxiety, and PTSD. rTMS may also be used to treat those living with Substance Use Disorders, Pain Disorders, Tinnitus, and Mild Cognitive Impairment (Early Dementia).

What to expect post-referral.
After we receive a referral from your provider, our staff will contact you to ask you some screening question, and to book your initial assessment.

INSTRUCTION PAGE – REFERRAL FORM ON PAGE 2.

BLOOM RTMS REFERRAL FORM

Repetitive Transcranial Magnetic Stimulation (rTMS) Program

Phone: (825)305-1042
Contact@bloomrtms.com
628 – 12th Avenue S.W. Calgary, Alberta
Suit 400, T2R 0H6

Please complete ALL information and fax to
BLOOM RTMS Clinic FAX: (825)252-5554

PATIENT'S PERSONAL INFORMATION

Name:			
Address		Apt. #	City, Town, Province
Postal Code	Home phone # Permission to contact patient at this #? ☐ Yes ☐ No		
Date of Birth	Business phone	Sex: F ☐ M ☐	

HEALTH INSURANCE INFORMATION

Is patient covered under Alberta Health Care Insurance Plan? No ☐ Yes ☐ ll Name on health card:_____	Health Card Number	Version code	Exp date

REFERRAL INFORMATION: To be completed and signed by referring physician

Referring Physician's Name:	Physician Billing #:	Tel: ( )	Fax: ( )

*** Signature of Referring Physician (mandatory)**

Family Physician Name Tel: ( ) Fax: ( )

Reason for Referral

(Select all that apply)

- ☐ **Treatment Resistant Depression**
- ☐ **Chronic Pain**
- ☐ **Mild Cognitive Impairment or Early Alzheimer's**
- ☐ **Generalized Anxiety Disorder**
- ☐ **Mild Traumatic Brain Injury**
- ☐ **Obsessive Compulsive Disorder**
- ☐ **PTSD**
- ☐ **Other:** _____