Sunnybrook
HEALTH SCIENCES CENTRE

Harquail Centre for Neuromodulation
PSYCHIATRIC REFERRAL
Please fax referrals to: **416-480-5318**
Attention: **Dr. Peter Giacobbe**

PATIENT INFORMATION:	
Last name:	First name:
Address:	
Date of Birth (dd/mm/yyyy):	OHIP #: Version code:
Phone number:	Can a message be left with another person? Y/N
*Name	*Relation:

REFERRING PHYSICIAN INFORMATION:	
Physician name:	MD Billing #:
Address:	
Phone number:	Fax #:

MAIN DIAGNOSIS:	
Major Depressive Disorder	Obsessive Compulsive Disorder
Bipolar Disorder	Eating Disorder (please specify):
Anxiety Disorder (please specify):	Alcohol Use Disorder
Post-Traumatic Stress Disorder	Other (please specify):

REASON FOR REFERRAL:
Details of referral (including target symptoms, goals of treatment and modality being considered – rTMS, tDCS, FUS, DBS, ECT):

Please indicate all medication(s) patient is CURRENTLY taking:				
Medication	Dose	Duration > 3 months (Y/N)	Benefits	Tolerability

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PSYCHIATRIC NEUROMODULATION REFERRAL
Please fax referrals to: **416-480-5318**
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Please indicate all psychiatric medication(s) patient has taken in the past:				
Medication	Dose	Duration > 3 months (Y/N)	Benefits	Tolerability

Please indicate any CURRENT or PAST psychotherapy patient has received:		
Type		Duration
CBT (Cognitive Behavioural Therapy)	Individual	
	Group	
Other (please specify):	Individual	
	Group	

CURRENT MEDICAL CONDITIONS:	
Substance Abuse (please specify):	History of Violent or Aggressive Behaviour:

Has patient been assessed by a psychiatrist or other mental health professional in the past? Y/N
If yes, it is critical that we receive the previous consultations on your patient in order to provide effective consultation. Please append them to your referral.

Name of Person Completing Form:	Date: (dd/mm/yyyy):
_____	_____