FEEL LIGHT
RTMS CLINIC

FEEL LIGHT REFERRAL FORM

Repetitive Transcranial Magnetic Stimulation (rTMS) Program

Phone: (647)-933-3697
Contact@FeelLight.ca
502 - 18 Kensington Rd Brampton, Ontario

Please complete ALL information and fax to
FEEL LIGHT Clinic FAX: 647-977-0126

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

	Health Card Number	Version code	Exp date
Name on health card: _____			

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:** _____

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