Dr. Paul Harris Corp MD CCFP
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Magnetic Potential Transcranial Magnetic Stimulation (TMS) Referral Form

Referring Provider (Physician, Psychologist, Registered Clinical Counsellor, or other qualified mental health professional): _____Fax #: _____

Phone #: _____ Email: _____

Date (DD/MM/YYYY): _____

Patient's Name: Surname First Name Middle Name

Date of Birth (DD/MM/YYYY): _____Phone #: _____

PHN#: _____

Address: _____ City: _____
Postal Code: _____

Diagnosis: _____

Please indicate whether any of the following apply to the patient (If "Yes", please describe in the space below or attach additional information.)

☐ Yes ☐ No Currently suffering from a major depressive episode according to DSM-5 criteria
☐ Yes ☐ No Failed to respond to two treatments with adequate dose and duration (treatments may include a course of psychotherapy)
☐ Yes ☐ No History of seizures in the patient or a first-degree relative
☐ Yes ☐ No Current suicidal thoughts
☐ Yes ☐ No Substance use/abuse, including alcohol (EtOH), cannabis, or other substances
☐ Yes ☐ No Prepared to allow follow-up contact via email/phone/text post-treatment

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Additional comments or relevant clinical information:

Note: Please attach a referral letter or clinical summary describing the patient's current and past mental health treatment, including any medications (with details of past trials and reasons for discontinuation, if applicable). Also attach any other relevant reports, psychological assessments, or documents.

Please return the completed form and attachments to:

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