



Fax: (888) 720-6140 Toll Free Phone: (888) 720-6040  
Calgary, AB T2G 5N9 • Edmonton, AB T5H 5P9  
[info@atmacena.com](mailto:info@atmacena.com) • [www.atmacena.com](http://www.atmacena.com)

**Referring Physician / Clinic Information:**

Clinic Name: \_\_\_\_\_  
Office Phone #: \_\_\_\_\_  
Office Fax #: \_\_\_\_\_  
Referring Physician: \_\_\_\_\_  
Prac ID: \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Electronic Signature Disclaimer:** By signing your name electronically on this referral form, you are agreeing that your electronic signature is the legal equivalent of your manual signature on this form.

**Patient Information:**

Last Name: \_\_\_\_\_  
First Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Gender: ☐ M ☐ F ☐ Non-Binary ☐ Prefer not to say  
DOB (dd/mm/yy): \_\_\_\_\_  
Primary Phone #: \_\_\_\_\_  
Email: \_\_\_\_\_  
Health Card#: \_\_\_\_\_

**Service offerings included in referral:**

- ☐ Initial Consultation
- ☐ Ketamine-Assisted Therapy
- ☐ Repetitive Transcranial Magnetic Stimulation
- ☐ Other Psychedelic-Assisted Therapies
- ☐ General Therapy

**Diagnosis:**

- ☐ MDD
- ☐ PTSD / cPTSD
- ☐ Anxiety
- ☐ Addiction
- ☐ Bipolar Affective Disorder

**Clinical Information:**

Height (cm): \_\_\_\_\_  
Weight (kg): \_\_\_\_\_  
Blood Pressure: \_\_\_\_\_  
BMI: \_\_\_\_\_  
Heart Rate: \_\_\_\_\_

**Reason for Referral or Diagnosis:****Other Specialists Involved in Care:****Relevant Past (Medical / Mental Health History):**

Please include a list of current medications and consultation reports with this referral. This Information will assist us to appropriately triage your patient.  
**Please fax all documents to (888) 720-6140.** Once all documentation is received and reviewed, a consultation appointment will be scheduled.

\*Please note that this is a private pay service.