



Fax: (403) 270-2037 Toll Free Phone: (888)720-6040
Calgary, AB 734 42 Ave SE, T2G 5N9 • Edmonton, AB #1155 5555 Calgary Trail NW, T6H 5P9
info@atmacena.com • 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 (403) 270-2037. Once all documentation is received and reviewed, a consultation appointment will be scheduled.

*Please note that this is a private pay service.