ATMA CENA

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

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.