ATMA CENA

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**Referring Psychologist / Clinic Information:**

Clinic Name: _____

Office Phone #: _____

Office Fax #: _____

Referring Psychologist: _____

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

**Reason for Referral or Diagnosis:**

**Other Specialists Involved in Care:**

**Relevant Past (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.