

rTMS Clinical Research Studies Physician Referral form

Location: The Royal's Institute of Mental Health Research (IMHR)
Sara Tremblay, PhD, Scientist & IMHR Psychiatrists

The Neuromodulation Unit is looking for participants with treatment-resistant major depressive disorder to take part in our repetitive transcranial magnetic stimulation (rTMS) clinical research studies.

Please note that all referrals are not automatically accepted. Patients will be contacted by telephone and pre-screened for suitability for a consultation with an IMHR rTMS clinic psychiatrist, which will be followed by a screening visit with the study research coordinator to establish if they are eligible to participate in the rTMS study. The IMHR psychiatrist in the rTMS clinic will provide a consultation report with a treatment plan to the referring physician and to the patient's primary care provider.

If your patient suffers from a major depressive episode and you would like them to be assessed for any of our current studies, **please complete the attached referral form and fax to 613-798-2973**. If you have any further questions, please find contact information on the attached form.

Sincerely,



Sara Tremblay, PhD, Study Investigator
Neuromodulation Unit

For more information about the study, please contact Stacey Shim at stacey.shim@theroyal.ca 613-722-6521 ext. 6356

Below is a checklist for the consultant to complete:

Inclusion criteria (<i>all criteria must be met</i>)	✓
Male/female, must be ≥ 18 years of age	
Primary or predominant diagnosis of major depressive disorder as a single or recurring episode, without psychotic features	
Depressive symptoms have not improved after ≥ 1 but ≤ 7 adequate dose of antidepressant trial in the current depressive episode	

Exclusion criteria (<i>if one exclusion is checked, the subject is not eligible</i>)	✓
Current or past (< 3 months) substance (excluding caffeine or nicotine) or alcohol abuse/dependence, as defined in DSM-5 criteria. <i>*Exception: prescribed cannabis</i>	
Acute suicidality or threat to life from self-neglect	
Are pregnant or breastfeeding, or thinking of becoming pregnant during course of treatment	
Have a specific contraindication for TMS (e.g., personal history of epilepsy or seizure, metallic head implant, pacemaker)	
<i>*Organic causes to the depressive symptoms (e.g. thyroid dysfunctions) have not been ruled out by the referring physician</i>	

Note: This is not a complete list of inclusion/exclusion criteria. All criteria will be assessed prior to participation in the study. If interested, participants have to agree that their primary physician is informed.

****Baseline investigations for ruling out possible organic causes to be sent to our clinic prior to the patient being scheduled, include:***

Complete blood count (CBC) and differential	Thyroid stimulating hormone (TSH)	Vitamin D – OHIP coverage for specific criteria*
Electrolytes, extended electrolytes: Na, K, Calcium, Mg, Phosphate	Fasting Blood Sugar Level (GBSL) and HbA1c	Vitamin B12
Blood Urea Nitrogen and Creatinine (BUN & Cr)	Fasting lipids (cholesterol, triglycerides)	Folic acid
Liver function tests (LFTs)	Iron (ferritin)	Urinalysis

* https://www.health.gov.on.ca/en/public/programs/ohip/changes/docs/MOH_Vitamin_D_FAQ.pdf

Any comorbid diagnoses (i.e. mood/personality/substance use disorders):

- | | |
|----------------------------------|---|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Psychotic Disorder |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Substance Use Disorder |
| <input type="checkbox"/> PTSD | <input type="checkbox"/> Personality Disorder |
| <input type="checkbox"/> OCD | <input type="checkbox"/> Other: _____ |

MEDICAL HISTORY

Does the patient have past/current medical conditions/illnesses/disabilities: Yes No

If yes, please indicate details (i.e. diagnosis, start date, has it been resolved – if yes, when? Any treatment or surgery received?):

MEDICATIONS/PSYCHOTHERAPY

(both psychiatric & non-psychiatric)

Current

Medication Name	Dose	Frequency	Response & Adverse Effects

Past (within current depressive episode)

Medication Name	Dose	Frequency	Response & Adverse Effects

Has the patient done any psychotherapy in the current depressive episode?

CBT
 IPT
 Problem Solving Therapy
 Other: _____

If any have been checked off, please indicate details (dates, duration and any benefits)

RISKS & SAFETY CONCERNS

Risk	Yes	No	If yes, when (DD-MM-YYYY)	Details
Suicide Attempt/Ideation	<input type="checkbox"/>	<input type="checkbox"/>		
Deliberate Self-harm	<input type="checkbox"/>	<input type="checkbox"/>		
Violent Behaviour/Safety Concerns	<input type="checkbox"/>	<input type="checkbox"/>		
Legal Involvement	<input type="checkbox"/>	<input type="checkbox"/>		
Fire Setting	<input type="checkbox"/>	<input type="checkbox"/>		
If any of the risks are selected "Yes", you are <u>required</u> to provide additional details				

PATIENT CONSENT FOR E-MAIL COMMUNICATIONS

Dear patient:

By consenting, you will be allowing your care provider and members of the rTMS research team at The Royal Ottawa Mental Health Centre (ROMHC) to communicate with you via e-mail. As with any online platform, it is important that you are aware of the following risks:

- Any inbound/outbound e-mail messages have the potential to be hacked and seen by others using the Internet. E-mail security can not be guaranteed as it may be easily forged, accidentally forwarded and may exist indefinitely. Thus, it is recommended that you do not use your e-mail to discuss information that you deem to be sensitive. If you do consent to e-mail, please let your care provider know if there is any type of information that you would prefer not to be discussed via e-mail (for example: test results, medications etc.).
- Do not use e-mail for any urgent communications, like in the event of an emergency, as it may not be received/read on time.

Please note:

- Your care provider may make decisions about your care based on information you provided via e-mail.
- If an e-mail has relevant information that is important to your clinical care, it may be copied/summarized into your medical record – similar to any phone communications.
- E-mails containing information relevant to your care, may be forwarded or read by other ROMHC staff members on an as needed basis. Your care provider will inform you if another person will read/respond to your e-mail on their behalf.

By providing your consent, we may use e-mail to communicate with you or your delegated person(s) outside the hospital.

You have the right to withdraw your consent to e-mail communications at any time, just let your care provider know as soon as possible.

By signing below, you consent to e-mail communications and its associated risks.

I _____, hereby consent to the ROMHC group to:

Print Name

Communicate with me by e-mail at: _____

E-mail Address

Communicate with _____, Relationship: _____

Delegated Person's Name

at: _____

E-mail Address

Communicate with the following outside care providers by e-mail: _____

Patient Signature

Signature Date (DD/MMM/YYYY)